

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**YOUTH SERVICES ADMINISTRATION
PART ONE: OAK HILL YOUTH CENTER**

**FINAL REPORT OF INSPECTION
MARCH 2004**



**AUSTIN A. ANDERSEN
INTERIM INSPECTOR GENERAL**

Inspections and Evaluations Division

Mission Statement

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness, and economy in operations and programs. I&E goals are to help ensure compliance with applicable laws, regulations, and policies, to identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



March 30, 2004

Ms. Yvonne D. Gilchrist
Director
Department of Human Services
2700 Martin Luther King Jr. Ave., S.E.
801 East Building
Washington, DC 20004

Dear Ms. Gilchrist:

Enclosed is our final *Report of Inspection of the Youth Services Administration (YSA), Part One: Oak Hill Youth Center*. Your agency's comments on the 45 findings and 96 recommendations by the inspection team are included, verbatim, in the body of the report following our findings and recommendations.

In accordance with Mayor's Order 2000-105, District agencies are responsible for taking action on all agreed-upon recommendations in this final Report. We are pleased to note your agreement with more than 90% of our recommendations. This clearly reflects your interest in taking the actions necessary to create a more efficient and better managed YSA.

The OIG has established a process to track agency compliance and to facilitate our follow-up inspection activities. Enclosed are *Compliance Forms* on which to record and report to this Office any actions you take concerning each outstanding recommendation. These forms will assist you in tracking the completion of actions taken by your staff. We track agency compliance with all agreed-upon recommendations made in our reports of inspection, and we request that you and your staff establish response dates on the forms, and advise us of those dates so we can enter them on our copies of the *Compliance Forms*.

In some instances, things beyond your control, such as budget decisions, inhibit setting specific deadlines for complying with certain recommendations. In those instances, we request that you assign *target dates* based on whatever knowledge and experience you have about a particular issue. Please ensure that all *Compliance Forms* are returned to the OIG by the response date, and that reports of "Agency Action Taken" reflect actual completion, in whole or in part, of a recommended action rather than "planned" action. We will work closely with your designated point of contact throughout the compliance process.

Letter to Yvonne D. Gilchrist
March 30, 2004
Page 2 of 3

We appreciate the cooperation shown by you and your employees during the inspection, and we hope to continue in a cooperative relationship during the upcoming follow-up period.

If you have questions or require assistance in the course of complying with our recommendations, please contact me or Alvin Wright, Jr., Assistant Inspector General for Inspections and Evaluations, at (202) 727-9249.

Sincerely,

A handwritten signature in black ink, reading "Austin A. Andersen". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Austin A. Andersen
Interim Inspector General

AAA/lp

Enclosure

cc: See Distribution

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TABLE OF CONTENTS

| | |
|---|-----------|
| EXECUTIVE SUMMARY | 2 |
| INTRODUCTION | 17 |
| Background and Perspective | 17 |
| Scope and Methodology | 18 |
| Compliance and Follow-Up | 19 |
| KEY FINDINGS..... | 21 |
| Long-Standing Management Deficiencies Continue | 21 |
| Millions of Dollars for Consultants Produced Limited Results | 27 |
| Illegal Substances Are Smuggled Into OHYC | 30 |
| Required Substance Abuse Treatment Program Not in Place | 32 |
| Contract Security Guards Allowed Breaches in Security | 34 |
| Background Checks for Employees Not Timely or Adequate | 37 |
| Vehicles Transporting Youths Not Inspected or Maintained | 39 |
| Employees Operate Vehicles Without Required Licenses | 41 |
| Correctional and Transportation Officers Lack Communication Equipment | 42 |
| Critical Staff Has No Telephones and Voicemail | 45 |
| Security Equipment in Female Housing Unit Is Deficient | 46 |
| Ratio of Youths to Correctional Officers Exceeds Requirement | 50 |
| Fire Safety Deficiencies Put Residents and Employees at Risk..... | 51 |
| Vacant Buildings Are Unsecured and Vandalized | 55 |
| Unusual Incidents Are Not Being Reported as Required..... | 59 |
| YSA's Fiscal and Asset Management Has Deficiencies..... | 60 |
| Serious Problems in IT Infrastructure May Impair Operations..... | 63 |
| SECURITY | 69 |
| Procedures, Staff Inadequate to Handle Escapes | 69 |
| Youth Correctional Officers Have No Emergency Response Training | 70 |
| Youths Are Not Photographed as Required | 71 |
| Physical Restraints Are Not Accounted For..... | 71 |
| Electronic Monitoring Equipment Is Inoperative..... | 72 |
| Control Booth Door Is Not Secured | 73 |
| Housing Units Lack Written Policies and Procedures | 75 |
| YOUTH SERVICES | 78 |
| Project Hands Managers Delay Completing Investigative Report..... | 78 |
| Drug Screening Program Has Serious Deficiencies..... | 79 |
| Deadlines for Developing Service Plans Are Unrealistic..... | 81 |
| Lack of Administrative Support For Treatment Team Leaders | 83 |
| Poor Communication Impedes Coordination of Youth Treatment Services..... | 83 |

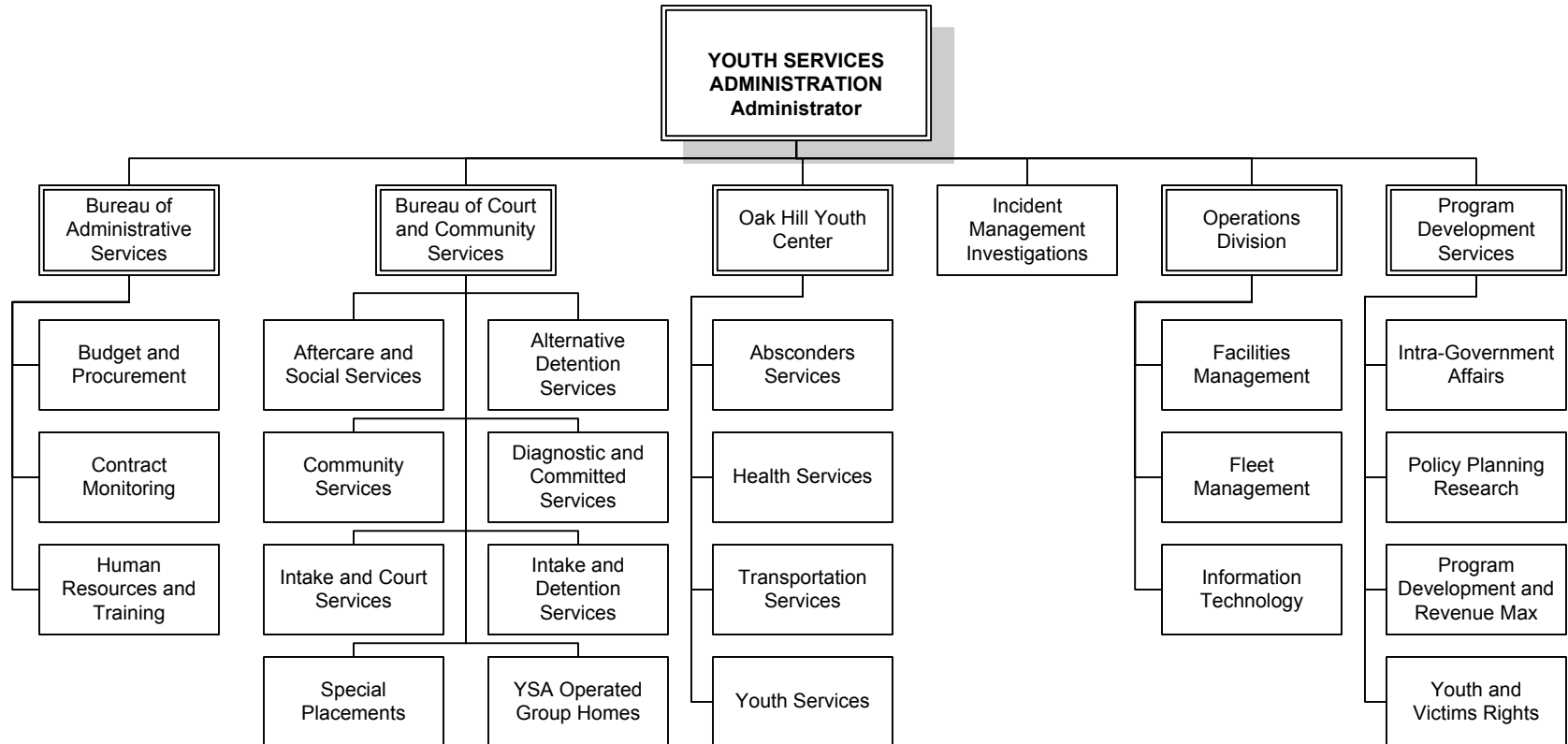
TABLE OF CONTENTS

| | |
|---|------------|
| Parents Are Not Participating in Treatment Plans as Recommended | 84 |
| Home Visitation Policies Are Not Uniformly Applied | 86 |
| OHYC Does Not Have a Registered Dietician | 87 |
| Meal Plans Do Not Conform with Religious Dietary Standards..... | 88 |
| Special Diets Create A Burden for Food Service Employees | 88 |
| Exercise Programs Do Not Comply With Decree..... | 90 |
| ENVIRONMENTAL HEALTH AND SAFETY | 93 |
| Culinary Unit Is Not Inspected for Fire and Safety Hazards | 93 |
| Culinary Unit Does Not Have Written Sanitation Policies and Procedures..... | 93 |
| Food Service Employees Lack Annual Physical Examinations..... | 94 |
| OHYC Does Not Have An Emergency Food Supply As Required | 95 |
| OHYC Has Numerous Deficiencies Affecting Health and Safety | 96 |
| ADMINISTRATION..... | 99 |
| OHYC Is Not An Accredited Facility | 99 |
| Institutional Review Committee Is Not Active | 100 |
| YCOs Are Not Following Time and Attendance Policies | 101 |
| YCOs Exceed YSA's Overtime Limits..... | 102 |
| YSA Is Not Complying With Training and Staff Development Standards | 103 |
| APPENDICES | 106 |
| Appendix 1: List of Findings and Recommendations | |
| Appendix 2: MAR 03-I-011 (Illegal Substances at OHYC) | |
| Appendix 3: Response to MAR 03-I-011 | |
| Appendix 4: MAR 03-I-007 (Breaches In Security at OHYC) | |
| Appendix 5: Response to MAR 03-I-007 | |
| Appendix 6: MAR 03-I-006 (Deficiencies in Motor Vehicle Pool) | |
| Appendix 7: Response to MAR 03-I-006 | |
| Appendix 8: MAR 03-I-008 (Lack of Communication Equipment) | |
| Appendix 9: Response to MAR 03-I-008 | |
| Appendix 10: MAR 03-I-009 (Deficiencies In Female Housing Unit) | |
| Appendix 11: Response to MAR 03-I-009 | |
| Appendix 12: MAR 03-I-010 (Fire Safety Problems) | |
| Appendix 13: Response to MAR 03-I-010 | |
| Appendix 14: MAR 03-I-013 (Abandoned Buildings at OHYC) | |
| Appendix 15: Response to MAR 03-I-013 | |

ORGANIZATION CHART



Youth Services Administration



ACRONYMS

ACRONYMS

| | |
|---------------|---|
| ACA | American Correctional Association |
| APRA | Addiction Prevention and Recovery Agency |
| A/YSA | Administrator of Youth Services Administration |
| BARJ | Balanced and Restorative Justice |
| BCCS | Bureau of Court and Community Services |
| BRSS | Bureau of Residential/Secure Services |
| DATIA | Drug and Alcohol Testing Industry Association |
| DCMR | District of Columbia Municipal Regulations |
| DCOP | District of Columbia Office of Personnel |
| DCPS | District of Columbia Public Schools |
| DECREE | Jerry M. Consent Decree |
| DHS | Department of Human Services |
| DMH | Department of Mental Health |
| DPM | District Personnel Manual |
| FEMS | District of Columbia Fire and Emergency Medical Services Department |
| ISP | Individual Service Plan |
| IT | Information Technology |
| JIMS | Juvenile Information Management System |
| MAR | Management Alert Report |
| MVO | Motor Vehicle Operator |
| OCFO | Office of the Chief Financial Officer |
| OCP | Office of Contracting and Procurement |
| OD | Officer of the Day |

ACRONYMS

| | |
|----------------|---|
| OHYC | Oak Hill Youth Center |
| OIC | Office of Investigations and Compliance |
| OIS | Office of Information Systems |
| PBS | Performance Based Standards Program |
| PCP | Phencyclidine |
| SAFE | Substance Abuse Free Environment |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SSR | Social Services Representative |
| T&A | Time and Attendance |
| TTL | Treatment Team Leader |
| YCO | Youth Correctional Officer |

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Background and Perspective

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) began an inspection of the District of Columbia (District) Department of Human Services (DHS), Youth Services Administration (YSA) in April 2003. YSA is a large agency responsible for a diverse portfolio of service providers and facilities. Consequently, the inspection is being conducted in two parts. Part One and this report cover YSA management, administrative services, and all operations at the Oak Hill Youth Center (OHYC)¹ in Laurel, Maryland. Part Two will cover the remaining major components of YSA and will be reported on separately.

YSA is the District's primary juvenile justice agency. According to its 2001 annual report,² YSA provides daily pre-trial and pre-dispositional secure and non-secure detention services to approximately 250 youths charged with delinquency at any given time. Each year, YSA also provides secure confinement, residential placements, and aftercare supervision and services for approximately 600 youths. YSA's stated mission is to empower youths entrusted to its care to become lawful, competent, and productive citizens. It performs this mission by:

- providing an integrated system of care, custody, and services involving youth, families and community;
- holding youths accountable in the least restrictive environment;
- establishing and implementing an individual service plan for each youth which assists in competency development, rehabilitation, and reintegration; and
- promoting public peace and community safety.

YSA has approximately 480 full-time employees, and its fiscal year (FY) 2003 operating budget was approximately \$53 million. The budget consisted of \$39 million in appropriated funds, and \$14 million in federal grants, intra-District funding, and social services block grants.

The inspection team (team) found many employees who were highly motivated and dedicated to carrying out YSA's mission. Unfortunately, however, the team also found very high employee turnover throughout YSA, particularly at the highest levels of management; poor management of operations and personnel; a significant number of youths testing positive for illegal substances while in YSA's custody; significant safety and security problems; a lack of written policies and procedures; and very low employee morale. The team also found indications of widespread waste and possible fraud, a lack of adequate checks and balances, and a lack of accountability for the use of YSA resources. The team found no significant deficiencies in the education and medical units at OHYC. In fact, the OHYC Academy, which comes under the District of Columbia Public School System, appears to be very well managed and operating successfully.

¹ The Oak Hill Youth Center (OHYC) is a secure facility for youths under both short-term and long-term detention. It is located in Laurel, Maryland, and has a court-ordered capacity of 188 males and 20 females.

² No annual report was issued in 2002 or 2003.

EXECUTIVE SUMMARY

Scope and Methodology

OIG inspections comply with standards established by the President's Council on Integrity and Efficiency, and pay particular attention to the quality of internal control.³

The inspection focused on the management and operations of key areas, including compliance with District of Columbia Superior Court mandates, security, transportation, culinary services, social services, case management services, and medical services. The team reviewed YSA's management of environmental health and safety procedures at OHYC. The team also reviewed best practices recommended by the American Correctional Association (ACA)⁴ and the operations of secure youth centers in surrounding jurisdictions. The team conducted 123 interviews and observed all major work areas and key work processes. This report contains 45 findings and 95 recommendations.

The Inspector General (IG) issued seven Management Alert Reports (MARs) on the following matters that the team found required the immediate attention of YSA Management and District of Columbia government officials:

- serious fire safety deficiencies, including inaccessible fire extinguishers, a lack of fire drills, and a lack of posted evacuation plans;
- serious breaches of security at entrances at OHYC due to a lack of adequate search procedures, and the employment of security guards without completed criminal background checks;
- deficiencies in the female housing unit that impair the ability of YCOs to effectively maintain the safety and security of residents and to ensure their own safety as well. These deficiencies included a lack of proper security monitoring equipment, insufficient perimeter lighting, a lack of proper communication equipment, and failure to provide all YCOs with keys to resident rooms in the event of an emergency;

³ "Internal control" is synonymous with "management control" and is defined by the General Accounting Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT, Introduction at 4 (Nov. 1999).

⁴ The team consulted "Standards for Juvenile Corrections Facilities," which was published February 2003 by ACA in cooperation with the Commission on Accreditation for Corrections (CAC). ACA and CAC are private, nonprofit organizations that administer the only national accreditation program for all components of adult and juvenile corrections. Their purpose is to promote improvement in the management of correctional agencies through the administration of a voluntary accreditation program and the ongoing development and revision of relevant, useful standards. Founded in 1870, the ACA is the oldest and largest international correctional association in the world. The standards set forth by the ACA provide administrators of juvenile facilities the opportunity to develop a plan for upgrading facilities and procedures in accordance with nationally recognized and respected benchmarks. The juvenile standards assist administrators in working effectively with the courts, legislatures, and the public. The juvenile correctional field is proceeding in a direction that provides more humane conditions in institutions, ensures the safety of staff and offenders, and provides programs and services necessary to assist juveniles in returning to society.

EXECUTIVE SUMMARY

- a lack of sufficient and reliable communication equipment which threatens overall safety and security and impairs the ability of Youth Corrections Officers (YCOs), transportation officers, treatment team leaders (TTLs), and social services representatives (SSRs) to perform their jobs effectively;
- illegal substances, such as marijuana and phencyclidine (PCP), smuggled into OHYC on a continual basis;
- documentation of 28 vacant and abandoned buildings at OHYC, many of which are unsecured and have been entered and vandalized; and
- employees operating government vehicles without valid state driver's licenses and government motor vehicle identification cards, and YSA vehicles being operated with expired inspection stickers.

Although most YSA employees were cooperative, responsive, helpful, and knowledgeable, the team found some managers less than helpful in providing requested information and explaining or clarifying OHYC operations.

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. Compliance forms with findings and recommendations will be sent to YSA along with this report of inspection (ROI). The OIG/I&E Division will coordinate with YSA on verifying compliance with recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

EXECUTIVE SUMMARY

FINDINGS AND RECOMMENDATIONS

Key Findings

Long-standing deficiencies in the management of OHYC and in attempts to comply with the Jerry M. Consent Decree continue to plague YSA despite millions spent on consultants. (Page 21) Numerous deficiencies documented over the years in consultant reports, most easily correctible, have not been addressed. Many of the same types of problems that resulted in the 1986 lawsuit against the District and the subsequent Court Decree regarding juvenile justice matters still exist 17 years later. In both its operational areas and personnel practices, YSA lacks sufficient internal policies and procedures, internal controls, and a system to ensure management and staff accountability. **Recommendations:** (a) That the Mayor give immediate consideration to removing YSA from DHS and forming a separate, cabinet-level agency whose director would report to the Deputy Mayor for Children, Youth, Families, and Elders (DMCYFE). (b) That the DMCYFE immediately address the most urgent problems cited in this OIG report and in previous reports by paid consultants. (c) That the DMCYFE and Director of YSA fully participate in the Performance-Based Standards system for improving juvenile facilities that has been developed under the sponsorship of the U.S. Department of Justice.⁵

YSA's use of consultants to help achieve compliance with the Jerry M. Consent Decree has been costly and largely ineffective. (Page 27) From 1998 through 2003, YSA spent approximately \$3.6 million on consultants in an effort to bring YSA into sustained compliance with the Decree. These projects often resulted in unauthorized overspending, unfulfilled objectives, and poor agency oversight. **Recommendation:** That the A/YSA, in order to minimize the duplication of previous efforts, coordinate a review and prioritization of all policies, procedures, assessments, and recommendations produced by past consultants, and identify those deliverables that can be salvaged and implemented.

Illegal substances such as marijuana and PCP are smuggled into OHYC regularly. (Page 30) The availability of illegal drugs at OHYC hinders treatment efforts and the recovery of residents with pre-existing substance abuse problems. OHYC staff members allegedly are the primary source of the illegal substances used by youths. A Management Alert Report (MAR 03-I-011, at Appendix 2) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 3. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA request that the DHS Office of Investigations and Compliance (OIC) investigate allegations by staff members that YCOs are transporting illegal substances into OHYC. The Director of DHS should report the results of that investigation to the Inspector General, and to other government entities as may be required by District, Maryland, or federal law. (b) That the A/YSA explore the feasibility of implementing a canine drug detection program for illegal substances at OHYC.

⁵ The Performance-based Standards (PbS) system was developed by the Council of Juvenile Correctional Administrators at the request of the Department of Justice to assist youth correction and detention facilities in continuously improving the conditions of confinement and the services provided. PbS is described as a tool that agencies can integrate into existing operations to develop, monitor, and sustain improvement. Details can be found at <http://www.performancebasedstandards.org>.

EXECUTIVE SUMMARY

OHYC does not have a substance abuse treatment program as required by the Decree and is in jeopardy of failing to qualify for federal grant funding. (Page 32) OHYC has been without a structured substance abuse treatment program since March 2003. The previous vendor chose not to renew its contract because OHYC could not provide the necessary therapeutic environment. Without a treatment program in place, YSA is not eligible to apply for a multi-year federal grant that is awarded by the U.S. Department of Justice. **Recommendation:** That the A/YSA expedite the procurement of a contract to provide drug educational and counseling services as required by the Decree and ensure that YSA is eligible to apply for the federal grant funding.

Contract security guards allowed serious security breaches at entrances to the OHYC Detention Facility. (Page 34) Inadequate searches by security guards jeopardized the safety of OHYC employees and youths, and allowed the entrance of contraband items, including drugs, into the secure detention facility. The control of pedestrians and vehicles entering OHYC's front gate was inadequate and sometimes negligent. A Management Alert Report (MAR 03-I-007, at Appendix 4) addressing these issues was sent to the A/YSA and other District officials. A copy of the A/YSA's response to the MAR is at Appendix 5. The team will follow up on the progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA provide adequate policies, procedures, and training for security guards to ensure that proper searches of all bags and packages of visitors and employees entering the secure detention facility are conducted. (b) That the A/YSA provide adequate policies, procedures, and training for security guards to ensure that effective frisk and pat search procedures are conducted on visitors and employees entering the secure detention facility. (c) That the A/YSA ensure that the gatehouse metal detector is operational and in use at all times. (d) That the A/YSA ensure that at least two security guards are present at the perimeter entrance gate and that security personnel adhere to all entrance security procedures. (e) That the A/YSA take immediate action to have the front gate restroom facilities repaired so that guards will not have a reason to leave the post unsecured.

YSA does not conduct adequate and timely background checks on those employees who have regular contact with youths. (Page 37) A number of YSA employees currently working closely with youths have not undergone background checks. Current background check procedures at YSA are limited to a search of Metropolitan Police Department records; YSA does not review national databases or the Central Registry of Crimes Against Children/Sex Offenders. **Recommendations:** (a) That the A/YSA ensure that all current employees with regular contact with youths and all applicants undergo a MPD criminal background check as required by current policy. (b) That the Director of the Department of Human Services propose legislation to the Mayor that would require and fund a complete background check for appropriate OHYC and other YSA employees, to include a check of the records at MPD and surrounding law enforcement jurisdictions, a NCIC check, and a review of the Central Registry of Crimes Against Children/Sex Offenders.

YSA vehicles are being operated with expired inspection stickers and without semi-annual preventive maintenance checks in violation of District Regulations. (Page 39) The team observed vehicles with either no inspection stickers or expired stickers, and vehicles that had not received required, semi-annual preventive maintenance checks. A Management Alert Report (MAR 03-I-006, Appendix 6) addressing these issues was sent to the A/YSA. A copy of the

EXECUTIVE SUMMARY

A/YSA's response to the MAR is at Appendix 7. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA ensure that all vehicles are properly inspected in accordance with District Municipal Regulations. (b) That the A/YSA discontinue the use of vehicles that do not contain valid inspection stickers. (c) That the A/YSA ensure that semi-annual preventive maintenance checks are conducted on all YSA vehicles. (d) That the A/YSA coordinate with DPW to either increase staffing levels for mechanics assigned to OHYC or allot additional days per week for the DPW mechanic to service and maintain YSA's fleet of vehicles.

YSA employees are operating government vehicles without valid state driver's licenses and government motor vehicle identification cards. (Page 41) Numerous YSA employees authorized to drive District vehicles had not provided validation of their state licenses and D.C. Government Motor Vehicle Driver Identification Cards, while others had expired D.C. Government Motor Vehicle Driver Identification Cards. A Management Alert Report (MAR 03-I-006, Appendix 6) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 7. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendation:** That the A/YSA ensure that all vehicle operators maintain current state driver's licenses and D.C. Government Motor Vehicle Identification Cards.

YCOs and transportation officers lack adequate communication equipment. (Page 42) Many YCOs on duty in the housing units do not carry two-way radios, and hard-wired telephones in some YCO offices are inoperative. Officers transporting youths outside of OHYC are not issued two-way radios or cellular telephones. The lack of adequate communication equipment threatens the safety of employees and youths. A Management Alert Report (MAR 03-I-008, at Appendix 8) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 9. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA ensure that each YCO on-duty at OHYC has a functional two-way radio for the duration of his or her shift. (b) That the A/YSA ensure that wired telephones are repaired or replaced so that the YCO office in each housing unit has a working telephone. (c) That the A/YSA provide additional telephones in each housing unit (i.e. a phone other than the one in the YCO office) to accommodate the youths' biweekly telephone calls. (d) That the A/YSA ensure that at least one transportation officer in addition to the driver is provided with a radio or cellular telephone in order to communicate with the OHYC security control office or with outside public safety agencies. (e) That the A/YSA discontinue the practice of allowing youths to use telephones in the YCO offices.

Not all staff members in the social services department of OHYC have a working telephone and voice mailbox. (Page 45) Not all of the treatment team leaders and social services representatives at OHYC have telephones in their unit offices and/or functioning mailboxes on the facility's voicemail system. These employees also provide critical, time sensitive information and updates to family members and off-site caseworkers. The lack of a telephone or an operable voice mailbox impedes an employee's abilities to provide responsive care and efficiently interact with all parties that participate in a youth's treatment and rehabilitation. A Management Alert Report (MAR 03-I-008 at Appendix 8) addressing these issues was sent to the A/YSA. A copy of

EXECUTIVE SUMMARY

the A/YSA's response to the MAR is at Appendix 9. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendation:** That the A/YSA ensure that employees in the Social Services Division (treatment team leaders, social services representatives, and their supervisors) have functioning telephones and voice mailboxes.

Inadequate equipment in the female housing unit impedes YCOs' effectiveness and creates potential hazards. (Page 46) YCOs in the female housing unit lacked adequate two-way radios, keys to residents' rooms, and security monitoring equipment. Uncomfortable working conditions and inadequate uniforms further erode the effectiveness of YCOs in this unit. A Management Alert Report (MAR 03-I-009, at Appendix 10) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 11. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR.

Recommendations: (a) That the A/YSA ensure that each YCO on duty in Unit 6 has a functional two-way radio for the duration of his or her shift. (b) That the A/YSA ensure that a working telephone is installed in the YCO security office. (c) That the A/YSA ensure that an emergency buzzer, direct phone line, or other notification device is connected between Unit 6 and the OHYC security control center to provide an alternative means of immediate communication in the event of an emergency. (d) That the A/YSA ensure that all electronic security monitoring equipment is repaired or replaced. (e) That the A/YSA ensure that YCOs keep the metal detector activated at all times, that batteries are installed in the hand scanner, and that the scanner is used in accordance with procedures. (f) That the A/YSA ensure the installation of adequate lighting for the exterior building perimeter. (g) That the A/YSA ensure that sufficient air conditioning and heating are provided in the YCO security office.

The ratio of youths to YCOs exceeds Decree requirements. (Page 50) OHYC often exceeds the 10:1 ratio of youths to YCOs required by the Decree. This leaves YCOs unable to effectively monitor youths' activities and ensure the security and safety of both youths and themselves. **Recommendation:** That the A/YSA take the necessary steps to ensure compliance with the youths-to-YCOs ratio.

Serious fire safety deficiencies may threaten the safety of residents and employees. (Page 51) Fire extinguishers were not readily available, fire drills were not being conducted, and emergency evacuation plans were not posted in critical areas. Also, the locks on housing unit doors have manual locks that require the use of a key, a time-consuming process that could pose a safety hazard in the event of a fire or other emergency. A Management Alert Report (MAR 03-I-010, at Appendix 12) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 13. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA ensure that all employees have access to fire extinguishers at all times. (b) That the A/YSA ensure that the fire extinguishers in the gymnasium are removed from the closet and reinstalled on the wall mounts. (c) That the A/YSA ensure that all deficiencies cited by the FEMS Fire Prevention Bureau are abated immediately. (d) That the A/YSA ensure that emergency evacuation plans are posted publicly in all key areas of OHYC. (e) That the A/YSA ensure that fire drills are conducted and documented quarterly as required. (f) That the A/YSA hire a trained Health and Safety Officer or provide adequate training to the designated OHYC employee who conducts monthly fire safety inspections. (g) That the A/YSA explore the feasibility of a central locking

EXECUTIVE SUMMARY

system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency. (h) That the A/YSA ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.

Numerous abandoned buildings at OHYC are unsecured and vandalized. (Page 55)

Vacant buildings on the grounds of the OHYC have been vandalized and in some instances fires have been set. Many of these unused buildings still have active electrical and water service. A Management Alert Report (MAR 03-I-013, at Appendix 14) addressing these issues was sent to the A/YSA. YSA did not respond to this MAR within the timeframe requested by the IG.

Recommendations: (a) That the A/YSA ensure that each abandoned building at the OHYC is secured against vandalism and safety risks. (b) That the A/YSA ensure that utility service to unused buildings is disconnected.

OHYC is not reporting unusual incidents to the DHS Office of Investigations and Compliance as required. (Page 59) OHYC is not submitting reports of unusual incidents, such as abuse, neglect, and suspicious injuries, to the Office of Investigations and Compliance (OIC) as required by DHS policy. This prevents DHS from properly tracking, investigating, and resolving unusual incidents at OHYC. **Recommendation:** That the A/YSA develop a system to ensure that all unusual incidents are promptly reported to DHS OIC.

YSA's fiscal and asset management has many deficiencies. (Page 60) The team found numerous deficiencies in YSA's contracting and procurement practices, participation in the D.C. Purchase Card program, and warehouse operations. District stakeholders cannot be assured that all services provided under contracts were delivered or delivered in the most cost effective manner. In addition, YSA's lack of proper oversight of the Purchase Card Program and the OHYC warehouse allows for the possibility of theft and mismanagement of District assets. **Recommendations:** (a) That the A/YSA and the District's Chief Procurement Officer conduct a review and audit of all YSA contracts to ensure compliance with District contracting and procurement regulations. (b) That the A/YSA request that the Office of Contracting and Procurement (OCP) and the Office of the Chief Financial Officer (OCFO) conduct an audit of the D.C. Purchase Card Program at YSA. (c) That the A/YSA implement programs to ensure control and accountability of the warehouse operations, and ensure that qualified employees are in charge.

Deficiencies within YSA's Information Technology (IT) infrastructure may impair YSA's ability to effectively manage its day-to-day operations. (Page 63) YSA's IT staff does not have the knowledge necessary to maintain and troubleshoot the Juvenile Information Management System (JIMS), YSA's mission critical computer application. Furthermore, JIMS cannot generate basic statistical reports that are vital to Decree compliance efforts. **Recommendations:** (a) That the A/YSA expedite meetings of representatives from DHS's Office of Information Systems, the District's Office of the Chief Technology Officer (OCTO), and YSA, to discuss engaging OCTO technical expertise until YSA employees can be sufficiently trained on JIMS. (b) That A/YSA give priority to ensuring that JIMS is made capable of producing all reports necessary for supporting OHYC supervision and tracking of detained and committed youths, as well as statistical information required by the court and other entities with a vested or otherwise appropriate interest in YSA operations. (c) That the A/YSA provide

EXECUTIVE SUMMARY

all units at OHYC with reliable, secure access to JIMS. (d) That the A/YSA ensure that all JIMS users receive appropriate training and ongoing IT support.

Security

YSA does not have adequate policies, procedures, or staff to handle an escape from OHYC. (Page 69) There are no written procedures at OHYC that detail the step-by-step process that should be followed in the event of an escape. The team also found that YSA does not have adequate, trained staff at OHYC to be mobilized in the event of an escape. **Recommendations:** (a) That the A/YSA ensure that thorough and complete escape procedures are drafted, implemented, and distributed to all key personnel. (b) That the A/YSA ensure that adequate, trained staff are available at OHYC to be mobilized in the event of an escape.

YCOs have not had emergency response training. (Page 70) YSA does not have written criteria that require YCOs to undergo emergency response training and YCOs do not have hands-on emergency response training. **Recommendations:** (a) That the A/YSA ensure that YCOs receive emergency response training. (b) That the A/YSA ensure that all YCOs receive a copy of the Hazard Continuity and Contingency Plan.

Youths are not photographed when remanded to YSA's custody. (Page 71) Youths are not photographed upon being remanded to the custody of YSA, which prevents YSA employees from accurately identifying youth at OHYC and could hinder efforts to find escapees. **Recommendation:** That the A/YSA ensure that each youth is photographed upon arrival at OHYC, and that a copy of this photograph is filed as required.

The number and location of physical restraints are not accounted for, and OHYC officials are not effectively monitoring their use. (Page 71) Accountability in the use and storage of physical restraints at OHYC is lacking. As a result, YSA cannot ensure that restraints are being used appropriately and with proper authorization. **Recommendation:** That the A/YSA follow established policies and procedures regarding the inventory and use of physical restraints.

Some OHYC electronic monitoring systems are inoperative. (Page 72) The team found several monitoring systems at OHYC inoperative, including systems in the gatehouse and the male and female housing units. The lack of functioning electronic monitoring systems prevents adequate surveillance of secured areas and could allow youths to escape undetected. **Recommendation:** That the A/YSA ensures that all electronic monitoring systems at OHYC are repaired and maintained.

The door to the gatehouse control booth at OHYC is not secured, which compromises facility security. (Page 73) The gatehouse serves as the entrance and exit into the OHYC secured facility, and the door to the gatehouse control booth is in need of repair and remains open and unlocked at all times. Unauthorized persons may gain entry to this area and assist youths in escaping. **Recommendations:** (a) That the A/YSA ensure that the hinges on the gatehouse control booth door are repaired. (b) That the A/YSA develop policies and procedures to ensure

EXECUTIVE SUMMARY

that the gatehouse control booth door remains locked and secured at all times. (c) That the A/YSA discontinue the storage of physical restraints in the gatehouse control booth area.

Policy and Procedures Manuals are not available in 9 of 11 youth housing units. (Page 75) Only 2 of the 11 housing units have written policies and procedures on site. Many procedures and directives are oral, which creates inconsistency in daily operations.

Recommendations: (a) That the A/YSA develop up-to-date policies and procedures that govern daily housing unit operations. (b) That the A/YSA ensure dissemination of the policy and procedures manual to all housing units upon development. (c) That the A/YSA maintain copies of all policies and procedures in a manual that is accessible to all employees and the public. (d) That the A/YSA ensure that policies and procedures are updated and distributed annually as recommended by ACA.

Youth Services

Project Hands management is not completing investigative reports within the 10-day requirement stipulated by the Decree. (Page 78) The internal, independent office at OHYC responsible for investigating and reporting all allegations of child maltreatment does not issue its investigative reports on time, which is in direct violation of the Decree and exposes the District to financial penalties for non-compliance. **Recommendation:** That the Director of DHS take necessary actions to ensure that the 10-day investigative report requirement is met.

YSA's drug screening program has serious deficiencies. (Page 79) YSA lacks written policies, procedures, and training for the collection of urine specimens, and has not established the "chain of custody" procedures necessary to safeguard the validity of the testing program. Also, accurate records are not kept of urine samples or drug test results. **Recommendations:** (a) That the A/YSA establish written policies and procedures for drug testing, and a training program for collectors of urine specimens. (b) That the A/YSA establish a chain of custody for the urine collection process. (c) That the A/YSA ensure accurate records are kept of the drug screening process.

YSA staff members are constrained by unrealistic diagnostic and reporting deadlines. (Page 81) The 2-week period mandated by the Decree for the development of a youth's Individual Service Plan (ISP) is insufficient to create an accurate initial assessment of a youth's strengths and needs. Many youths enter OHYC with drugs in their systems and are under the influence of one or more drugs during much of the diagnostic period. In addition, ISPs at OHYC must be updated every 30 days. Diagnostic and update timeframes in other jurisdictions are more generous. **Recommendation:** That the A/YSA request a meeting with the court-appointed monitors and the Decree plaintiffs' attorneys to negotiate an extension of the diagnostic timeframe and reporting requirements in order to ease the administrative burden created by the current treatment plan deadlines.

Administrative support for OHYC treatment team leaders is insufficient. (Page 83) Treatment team leaders have not been provided adequate administrative help and spend a disproportionate amount of time on administrative tasks rather than providing individual and group therapy, or working on therapeutic programming for youths in their units. The need for

EXECUTIVE SUMMARY

additional help is particularly acute on those units that deal with detained youths because the turnover rate is much higher in the detained population compared to that of the committed population. **Recommendation:** That the A/YSA expedite the hiring of additional personnel to adequately support the treatment team leaders.

Poor communication between departments at OHYC impedes the coordination of services and the treatment of youths. (Page 83) Numerous D.C. government agencies, such as the Department of Health, the Department of Mental Health, and the District of Columbia Public Schools, provide services to each youth at OHYC, but YSA does not hold regular monthly meetings attended by representatives from each one of the major agencies. This lack of communication can lead to poor coordination of treatment efforts and the inefficient execution of the various elements of a youth's ISP. **Recommendation:** That the A/YSA Administrator reinstate the practice of convening a meeting of all OHYC department heads on a regularly monthly basis.

Parent participation in diagnostic and treatment team meetings at OHYC is extremely low. (Page 84) The majority of parents do not participate in diagnostic and treatment team meetings due to time and location constraints. Parents and guardians should be key participants in the rehabilitative process, and, when excluded from treatment team meetings, they miss an opportunity to interact not only with their child but also with those OHYC staff members who provide services to their child. **Recommendations:** (a) That the A/YSA procure telephone equipment and service in the room where the weekly treatment team meetings are held so that parents will be able to participate in these meetings via teleconference. (b) That the A/YSA lead an initiative, staffed by members from all of OHYC's major departments, to identify additional ways to improve parent participation in the treatment team process.

OHYC home visitation policies are not uniformly applied. (Page 86) Home visitation privileges are not uniformly granted, which dissuades many youth from working toward their treatment goals and striving for good behavior at OHYC. **Recommendation:** That the A/YSA ensure that the home visitation policy is reviewed and more uniformly applied.

OHYC does not have a dietician to ensure compliance with nationally recommended daily food allowances. (Page 87) OHYC does not have a dietician, and a review of the meals prepared and served at OHYC has not been conducted for a number of years. The Master Menu used to prepare meals at OHYC has not been updated to reflect changes in recommended dietary allowances. **Recommendation:** That the A/YSA hire a full-time dietician or a dietary consultant to review menus and ensure compliance with federally recommended daily food allowances.

OHYC does not have written policies and procedures for youths who require special diets due to religious dietary standards. (Page 88) OHYC lacks a written policy for special diets based upon religious beliefs or other dietary constraints. The absence of a written policy might delay the implementation of special diets for youths who request such diets. **Recommendation:** That the A/YSA seek either internal or external expertise in developing written policies and procedures for dietary plans for youths with religious beliefs that require special diets.

EXECUTIVE SUMMARY

The number of special diets approved by medical unit personnel creates a burden for culinary workers. (Page 88) At one point during the inspection, 60 of 163 OHYC youths were on special diets for medical reasons. OHYC does not have a dietician to approve special diets and the culinary unit cannot be assured that they are preparing correct special meals based upon these medical alerts. Additionally, due to the number of youths stating their need for a special diet and inadequate food allergy testing, these requests create a burden for the food service staff by increasing the number of special meals they must prepare each day. **Recommendations:** (a) That the A/YSA coordinate with medical unit employees and develop and implement written policies and procedures for youth with special diets. (b) That the A/YSA direct the food service manager and medical unit personnel to review all special diets monthly to ensure that dietary information is current. (c) That the A/YSA direct medical unit personnel to verify youths' medical histories and provide testing of youth for allergens prior to placing them on special diets.

Large muscle exercises for youths are limited and do not comply with the Decree. (Page 90) Youth are not participating in a full range of large muscle exercises, and recreation activities are severely limited by insufficient space and outdoor lighting. **Recommendations:** (a) That the A/YSA direct the Supervisory Recreation Specialist to closely monitor documentation submitted by the Recreation Specialists to ensure compliance with the Decree. (b) That the A/YSA improve the outside lighting throughout the facility to ensure that all youths are able to participate in a range of individual and group activities as mandated.

Environmental Health & Safety

OHYC does not conduct weekly fire and safety inspections of the food service areas. (Page 93) OHYC does not have written policies or procedures requiring weekly fire and safety inspections and could not produce documents verifying that fire and safety inspections of the food service area have been conducted. Without regular fire and safety inspections, YSA cannot ensure the health and safety of youths and employees in the food service areas. **Recommendations:** (a) That the A/YSA develop policies and procedures requiring weekly fire and safety inspections of the food service areas. (b) That the A/YSA provide fire and safety inspection training for the employee(s) responsible for these inspections.

The Culinary Unit does not have written sanitation policies and procedures. (Page 93) The culinary unit did not have copies of federal, state, or local sanitation and health codes for review. The lack of readily available sanitation and health codes leaves the interpretation of codes to each food service employee and could lead to inconsistent implementation and health risks to youths and employees. **Recommendations:** (a) That the A/YSA develop written sanitation policies and procedures for the food service areas. (b) That the A/YSA obtain and distribute to each food service employee copies of applicable sanitation and health codes.

Food service employees do not undergo annual physical examinations. (Page 94) YSA requires all food service employees to undergo a physical examination prior to being hired, but does not have written policies and procedures requiring employees to undergo annual reexaminations. Annual physical examinations ensure that food service employees are in good health and free of communicable diseases, which might be transmitted while preparing or serving food. **Recommendation:** That the A/YSA develop and implement a written policy and

EXECUTIVE SUMMARY

procedure that requires food service employees take annual physicals at the time of employment to include subsequent annual physical reexaminations.

OHYC does not maintain a reserve supply of food for emergencies as specified in its Emergency Response Contingency Plan. (Page 95) The culinary unit at OHYC is not prepared to provide food in the event of an emergency that required total containment of the facility. Emergency food items have not been procured and the freezer designated for use in the Contingency Plan contained furniture and supply items. **Recommendation:** That the A/YSA expedite the procurement of emergency food items in accordance with the Emergency Response Contingency Plan.

OHYC has not been inspected for environmental, health, and safety deficiencies. (Page 96) The inspection team noted inadequate ventilation and temperature control, leaking pipes, possible electrical code violations, and evidence of rodent infestation. Due to inadequate repairs and maintenance, YSA cannot protect the health and safety of residents, employees, and visitors at OHYC. **Recommendation:** That the A/YSA request an inspection of OHYC by the District of Columbia Office of Risk Management to determine whether there are any hazards to residents, employees, and visitors, and if any measures can be taken to address these hazards.

Administration

OHYC is not an accredited youth detention facility. (Page 99) Accreditation inspections are conducted by an outside team of peer inspectors, and provide a realistic assessment of the quality of the facility and recommendations for improvement. However, OHYC is not an accredited youth detention facility and has never been inspected by an external entity. There are no District regulations requiring inspection, accreditation, or independent evaluation of the facility. **Recommendations:** (a) That the A/YSA take the necessary steps to have OHYC inspected and evaluated by the ACA. (b) That the A/YSA work with the City Council and the Mayor in proposing legislation requiring OHYC to become an accredited facility.

The Institutional Review Committee, an important quality assurance mechanism within YSA, is not active. (Page 100) YSA's Institutional Review Committee (IRC) was established to serve as a quality assurance mechanism with authority to make final decisions on case management disputes. The IRC should also play a role in evaluating each caseworker's performance. The team found that the IRC is not a standing, active committee and that it has not met for a number of months. **Recommendation:** That the A/YSA immediately reactivate the Institutional Review Committee.

YCOs are not adhering to time and attendance policies. (Page 101) YCOs are not signing the Daily Sign-In/Out Sheets upon arrival to work and upon completion of their tour of duty, which makes it difficult for the Time and Attendance (T&A) Clerk to verify their presence at work on specific dates and the number of hours worked. Failure to adhere to this policy creates a potential for T&A fraud. **Recommendations:** (a) That the Officers-of-the-Day ensure that all YCOs sign the Daily Sign-In/Out Sheets upon their arrival and departure from work. (b) That the Officers-of-the-Day review the Daily Sign-In/Out Sheets for signatures and obtain any missing signatures prior to forwarding the sheets to the T&A Clerk.

EXECUTIVE SUMMARY

YCOs are exceeding the 24-hours-per-pay-period limit on working overtime. (Page 102) YSA has an internal policy that limits the amount of overtime YCOs can work per pay period to 24 hours. YCOs are consistently exceeding the 24-hour limit and averaging 30-60 overtime hours per pay period. **Recommendation:** That the A/YSA enforce compliance with the 24-hours-per-pay-period limit on overtime worked by YCOs.

YSA is not complying with follow-up training and staff development programs at OHYC as required by the Decree. (Page 103) Although YSA is complying with ACA training standards for employees during their first year on the job, employees are failing to meet the training requirements during subsequent years as mandated by the Decree. Not only does YSA risk the imposition of fines for non-compliance, but it also cannot be assured that OHYC employees are familiar with updated or new operational procedures. **Recommendation:** That the A/YSA take the necessary steps, to include appropriate administrative action, to ensure that all affected employees meet the training requirements as set forth in the Decree.

INTRODUCTION

INTRODUCTION

Background and Perspective

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) began an inspection of the District of Columbia (District) Department of Human Services (DHS), Youth Services Administration (YSA) in April 2003. YSA is the District's primary juvenile justice agency, and is responsible for a diverse portfolio of service providers and facilities. Consequently, the inspection is being conducted in two parts. Part One and this report cover YSA management, administrative services, and all operations at the Oak Hill Youth Center (OHYC) in Laurel, Maryland. Part Two will cover the remaining major components of YSA and will be reported on separately.

According to its 2001 annual report, YSA provides daily pre-trial and pre-dispositional secure and non-secure detention services to approximately 250 youths charged with delinquency. Each year, YSA also provides secure confinement, residential placements, and aftercare supervision and services for approximately 600 youths. The mission of YSA is to empower youths entrusted to its care to become lawful, competent, and productive citizens. YSA performs its mission by:

- providing an integrated system of care, custody, and services involving youth, families, and community;
- holding youths accountable in the least restrictive environment;
- establishing and implementing an individual service plan for each youth which assists in competency development, rehabilitation, and reintegration; and
- promoting public peace and community safety.

YSA is overseen by an Administrator (A/YSA) and has approximately 480 full-time employees. YSA's fiscal year (FY) 2003 operating budget was approximately \$53 million, and consisted of \$39 million in appropriated funds, and \$14 million in federal grants, intra-District funding, and social services block grants.

The inspection team (team) found many YSA employees to be highly motivated and dedicated to carrying out YSA's mission. Unfortunately, however, the team found very high employee turnover, particularly at the highest levels of management; poor management of operations and personnel; a significant number of youths testing positive for illegal substances while in YSA's custody; significant safety and security problems; a lack of promulgated, written policies and procedures; and very low employee morale. The team also found indications of widespread waste and possible fraud, a lack of adequate checks and balances, and a lack of accountability for the use of YSA resources. The team found no significant deficiencies in the education and medical units at OHYC. In fact, the OHYC Academy, which comes under the District of Columbia Public School System, appears to be very well managed and operating successfully.

INTRODUCTION

Scope and Methodology

OIG inspections comply with standards established by the President's Council on Integrity and Efficiency, and pay particular attention to the quality of internal control.

The inspection focused on the management and operations of key areas, including compliance with District of Columbia Superior Court mandates, security, transportation, culinary services, medical services, social services, and case management services. The team also reviewed YSA's management of environmental health and safety procedures at OHYC. The team reviewed best practices recommended by the American Correctional Association (ACA),⁶ and the operations of secure youth centers in surrounding jurisdictions. The team conducted 123 interviews, issued an anonymous and confidential employee survey, and observed all work areas and key work processes. This report contains 45 findings and 95 recommendations.

The Inspector General (IG) also issued seven Management Alert Reports (MARs) on the following matters that the team found required the immediate attention of YSA management and District of Columbia government officials:

- employees operating government vehicles without valid state driver's licenses and government motor vehicle identification cards and YSA vehicles being operating with expired inspection stickers;
- serious breaches of security at entrances at OHYC due to a lack of adequate search procedures and the employment of security guards without completed criminal background checks;
- a lack of sufficient and reliable communication equipment which threatens overall safety and security and impairs the ability of Youth Corrections Officers (YCOs), transportation officers, treatment team leaders, and social services representatives to perform their jobs effectively;
- deficiencies in the female housing unit that impair the ability of YCOs to effectively maintain the safety and security of residents and to ensure their own safety as well. These deficiencies included a lack of proper security monitoring equipment, insufficient perimeter lighting, a lack of proper communication equipment, and

⁶ The team consulted "Standards for Juvenile Corrections Facilities," which was published February 2003 by ACA in cooperation with the Commission on Accreditation for Corrections (CAC). ACA and CAC are private, nonprofit organizations that administer the only national accreditation program for all components of adult and juvenile corrections. Their purpose is to promote improvement in the management of correctional agencies through the administration of a voluntary accreditation program and the ongoing development and revision of relevant, useful standards. Founded in 1870, the ACA is the oldest and largest international correctional association in the world. The standards set forth by the ACA provide administrators of juvenile facilities the opportunity to develop a plan for upgrading facilities and procedures in accordance with nationally recognized and respected benchmarks. The juvenile standards assist administrators in working effectively with the courts, legislatures, and the public. The juvenile correctional field is proceeding in a direction that provides more humane conditions in institutions, ensures the safety of staff and offenders, and provides programs and services necessary to assist juveniles in returning to society.

INTRODUCTION

- failure to provide all YCOs with keys to resident rooms, in the event of an emergency;
- serious fire safety deficiencies, including inaccessible fire extinguishers, a lack of fire drills, and a lack of posted evacuation plans;
 - illegal substances, such as marijuana and phencyclidine (PCP), smuggled into OHYC on a continual basis; and
 - documentation of 28 vacant and abandoned buildings at OHYC, many of which are unsecured and have been entered and vandalized.

Although most YSA employees were cooperative, responsive, and knowledgeable, the team found some managers less than helpful in providing requested information and explaining or clarifying OHYC operations.

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. Compliance forms with findings and recommendations will be sent to YSA along with this report of inspection (ROI). The OIG/I&E Division will coordinate with YSA on verifying compliance with recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

Findings and Recommendations:

KEY FINDINGS

KEY FINDINGS

Jerry M., a youth incarcerated in one of the District's juvenile detention facilities in 1985, became the representative of a class of detained and committed youths who were confined at juvenile facilities under the authority of the District of Columbia (the District). In 1985, in an effort to improve conditions for confined youths, attorneys from the Public Defender Service and the American Civil Liberties Union's National Prison Project filed a class-action lawsuit against the District.⁷

In 1986, the parties settled the lawsuit by reaching an agreement to resolve the issues in litigation, and the court approved what became known as the "Jerry M. Consent Decree" (Decree). The Decree provided for minimum compliance standards for the District's incarcerated youth population and facilities, to include staff discipline and training, institutional programs, youth discipline, restraints, environmental health, medical services, visitation policies, attorney access, home visits, rights of residents, and youth sanctions.

The Decree also required that a monitor be assigned to observe, collect information, report findings, and make recommendations concerning steps to be taken by the District to achieve compliance with the Decree. The monitor is required to submit quarterly reports to counsel for the respective parties, and provide semi-annual reports to the Superior Court of the District of Columbia (Court). These reports detail whether the District is in compliance with each provision of the Decree. The agreement stipulates that failure by YSA to comply with provisions of the Decree could result in legal and financial sanctions against the District.

In January 2004, a consultant hired by the attorneys for the Jerry M. plaintiffs accused YSA and the District of failing to implement the changes necessary to comply with the Decree and subsequent orders of the Court. The consultant recommended that the Court appoint a temporary receiver for YSA, and a hearing on the matter was scheduled for February 23, 2004.

1. Long-standing deficiencies in the management of OHYC and in attempts to comply with the Jerry M. Consent Decree continue to plague YSA, despite millions of dollars spent on consultants.

Despite YSA's use of a series of paid consultants, long-standing problems have persisted in YSA's management and administrative operations, its compliance with the Decree, and in the operations of OHYC. Numerous deficiencies and recommendations documented in consultant reports have not been addressed. For example, in a March 2001 report entitled "Renovation Plan for Oak Hill Youth Center," a consultant detailed problems with insufficient perimeter lighting at Unit 6, which houses female detainees. Almost 3 years later, in January 2004, our inspection team also noted this same deficiency in a Management Alert Report (MAR 003-I-009). In another example, consultants noted significant deficiencies in inventory accounting and control at the YSA warehouse in a June 2001 report, and made very detailed recommendations on how to improve operations. However, many of the same deficiencies remain uncorrected as of this writing.

⁷ *Jerry M., et al. v. District of Columbia, et al.*, Superior Court of the District of Columbia Civil Division, C.A. No. 1519-85 (IFP).

KEY FINDINGS

The inspection team found that many of the same types of problems that resulted in the 1986 lawsuit against the District and the subsequent Decree regarding juvenile justice matters still exist 17 years later. The Court has noted issues of non-compliance with almost every substantive provision of the Decree by issuing more than 65 remedial orders and holding the District in contempt on several occasions.⁸ Documents obtained from YSA show that as of October 2003, YSA still was not in full compliance with approximately one-third of the 185 provisions of the Decree.

The inspection team believes that many of the continuing problems at OHYC cited in this report stem from: (a) the lack of stable leadership at senior levels of YSA, and (b) insufficient oversight by senior management at DHS who may be too far removed from YSA's day-to-day operations and the youths being served.

YSA has extreme difficulty retaining its top managers; for example, there have been four different Administrators (YSA's top position) during the 9 months of this inspection. In addition, other senior positions either have been vacant or filled for long periods by employees in "acting" or "interim" status (see table next page). Based on its interaction with YSA employees, the team believes this leadership void has a very negative impact on discipline, dedication, morale, and loyalty. Too many employees are not performing their day-to-day tasks satisfactorily, which, in turn, results in operational breakdowns across the board in security, oversight, monitoring of youths, administrative operations, facility maintenance, resource tracking, computer systems, and other areas.

The continuous state of dysfunction in YSA strongly indicates that the management and leadership of senior DHS and YSA officials have been weak and ineffective. In both its operational areas and personnel practices, YSA lacks sufficient internal policies and procedures, internal controls, and a system to ensure management and staff accountability.

These deficiencies are serious and have minimized the effectiveness and efficiency of YSA operations. Consequently, the inspection team rates YSA a poorly performing component of the District's juvenile justice system, based on District government and nationally accepted standards of quality. In particular, the team found:

- poor communication between major departments at YSA;
- employee roles and responsibilities not clearly defined;
- few or no standard policies and procedures for OHYC operations;
- inadequate fiscal oversight in all areas;
- a lack of quality assurance and performance standards;
- unimplemented recommendations for improvements made by various experts;
- a lack of effective monitoring of programs provided to youths; and
- little assertiveness in actions and attitudes directed toward compliance with the Jerry M. Decree.

⁸ *Jerry M., et al. v. District of Columbia, et al.*, Order VI, June 19, 2003.

KEY FINDINGS

Department of Human Services Youth Services Administration Key Employee Vacancies⁹ as of November 7, 2003

| Office of the Administrator | Status |
|--|------------------------------------|
| Administrator | Acting Administrator ¹⁰ |
| Incident Management Investigator | Vacant |
| Attorney Advisor | Vacant |
| Bureau of Administrative Services | |
| Chief Administrative Officer | Vacant |
| Deputy Administrative Officer | Vacant |
| Deputy Administrative Officer for Human Resources and Training | Vacant |
| Training Manager | Vacant |
| Operations Division | |
| Chief Operating Officer | Vacant |
| Preventive Maintenance Forman | Vacant |
| Bureau of Residential/Secure Program Services (Oak Hill Youth Center) | |
| Deputy Administrator | Vacant |
| Superintendent, Oak Hill | Vacant |
| Supervisor of Absconder Services | Vacant |
| Assistant Superintendent for Treatment | Vacant |
| Program Development Services | |
| Social Services Officer | Vacant |
| Program Manager Officer | Vacant |
| Bureau of Court and Community Services | |
| Assistant Deputy for Intake and Detention | Vacant |
| Assistant Deputy for Diagnostic and Committed Services | Vacant |

⁹ Department of Human Services, Youth Services Administration, Organizational Chart for FY 2003.

¹⁰ There were four Administrators or Acting Administrators between May 2003 and February 2004.

KEY FINDINGS

The team believes that, given a reasonable period of time, a highly experienced manager with a background in juvenile justice who is accountable directly to the Executive Office of the Mayor, can bring stability and focus to YSA operations, and put the agency on the path to meeting all requirements of the Jerry M. Decree.

Recommendations:

- a. That the Mayor give immediate consideration to removing YSA from DHS and forming a separate, cabinet-level agency whose Director reports to and is directly and sufficiently overseen by the Deputy Mayor for Children, Youth, Families, and Elders (DMCYFE).

Agree _____ Disagree _____ **X**

DHS's Response to IG's Recommendation, as Received:

DHS does not agree with OIG's factual findings. The current leadership at DHS is capable of providing the management oversight necessary for YSA. This leadership has over 30 years of management experience in child welfare and youth services. Coupling this experience with the Interim Management staff of YSA and direction from the City Administrator will indeed yield the positive results that are needed for YSA.

DHS disagrees with the generalized statement in this section "that many of the continuing problems at OHYC cited in this report stem from: (a) the lack of stable leadership at senior levels of YSA, and (b) insufficient oversight by senior management at DHS who may be too far removed from YSA's day-to-day operations and the youths being served." DHS further disagrees with the inspection team's statements that "YSA has extreme difficulty retaining its top managers; for example, there have been four different Administrators (YSA's top position) during the 9 months of this inspection" and that "[t]he continuous state of dysfunction in YSA strongly indicates that the management and leadership of senior DHS officials have been weak and ineffective."

These three subjective, qualitative assessments of DHS and YSA leadership and management are misleading without context. First, this OIG inspection of DHS/YSA began in April 2003, prior to the arrival of the current agency leadership: the incumbent DHS Director has only been in place since June 16, 2003, and the Interim A/YSA was appointed on December 3, 2003.

Second, prior to the recent series of acting administrators that commenced with the resignation of the previous A/YSA effective August 31, 2003, YSA enjoyed five years of continuous leadership.

Third, the chart included in this section entitled, "Key Employee Vacancies as of November 7, 2003," identifies 17 "key" vacancies. This chart is misleading because of its failure to recognize the valuable input of the highly qualified employees who have served in acting or interim capacities performing the duties of these positions. As of this writing, 385 of

KEY FINDINGS

YSA's 480 authorized FTEs are filled. Of these remaining positions, 60 are in recruit status and 35 are vacant. The DHS Director and current Interim A/YSA moved to fill a number of other "key" vacancies by hiring 17 employees in December 2003, including the Assistant Superintendents for Treatment for both the OHYC and the new Youth Services Center (YSC), which is set for beneficial occupancy in August 2004. YSA has requested funding and an additional 71 FTEs in FY 2005 to staff the YSC and to implement Jerry M. compliance and organizational improvements. Understandably, the ongoing nationwide recruitment effort by the D.C. Office of Personnel (DCOP) for a permanent A/YSA is made especially difficult while plaintiffs' motion for appointment of a transitional receiver is pending before the Superior Court in the Jerry M. litigation.

YSA efforts to fill its vacancies is exacerbated by the fact that the YSA organization chart signed on March 22, 2003, by the former DHS Director has never been fully implemented. As part of her management reform initiative, the Interim A/YSA proposes to reorganize YSA to include four Deputy Administrators to lead the agency as follows: (1) Deputy Administrator for Secure Programs; (2) Deputy Administrator for Court and Community Programs; (3) Deputy Administrator for Support Services (functionally, Chief Administrative Officer); and (4) Deputy Administrator for Performance Management. These four deputies are being recruited and the incumbents will be involved in hiring direct report managers within their respective operational responsibilities. The former Bureau of Residential/Secure Program Services will become the Division of Secure Programs to oversee both OHYC and YSC operations. The former Bureau of Court and Community Services will become the Division of Court and Community Programs. The former Bureau of Administrative Services and Operations Division will be combined to form the Division of Support Services. A Division of Performance Management will be created, which will include the functions performed by Program Development Services.

With reference to the deficiencies itemized in this section, YSA anticipates that:

- the four Deputy Administrators will facilitate better communications between these major YSA divisions;*
- the Deputy Administrator for Support Services will oversee a YSA-wide overhaul of human resource management in conjunction with the Office of Labor Relations and Collective Bargaining (OLRCB) and DCOP;*
- the Deputy Administrator for Performance Management will work with the Deputy Administrator for Secure Programs, the Superintendent for both OHYC and YSC, and the Assistant Superintendents for Treatment for both facilities to establish and implement standard policies and procedures for OHYC and YSC operations;*
- the Deputy Administrator for Support Services will institute fiscal control in all areas;*
- the Deputy Administrator for Performance Management will continue YSA's participation in the Performance-based Standards program and will implement other quality assurance and performance standards for the agency;*

KEY FINDINGS

- *these infrastructure improvements will enable the agency to successfully implement the specific management recommendations made by the various experts and the OIG;*
- *current licensing and monitoring initiatives for group and shelter homes, in concert with a fully implemented Division of Performance Management, will facilitate effective monitoring of programming for youth; and*
- *this management team will facilitate implementation of results-focused, purpose-driven, massive action plans to achieve compliance with the Jerry M. Consent Decree.*

OIG Response: **OIG stands by recommendation as stated.**

- b. That the DMCYFE and Administrator of YSA take immediate action to address the most urgent problems cited in the Key Findings section of this report and in reports by paid consultants, particularly issues of security, safety, health, and illegal substances.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

DHS and/or YSA responded to each of the MARs issued during the course of the OIG's investigation in Part One of this ROI, and continue to take action to address the issues of, among others, security, safety, health, and illegal substances. By agreeing with this recommendation, however, DHS does not necessarily agree with each of OIG's 45 factual findings or 96 recommendations.

- c. That the DMCYFE and Administrator of YSA fully participate in the Performance-based Standards (PbS) system¹¹ for juvenile facilities that has been developed by the Council of Juvenile Correctional Administrators under the sponsorship of the U.S. Justice Department.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

YSA already participates in the PbS system for juvenile facilities developed by the Council of Juvenile Correctional Administrators (CJCA). YSA first began contributing data to the PbS data portal during the first reporting period in 2001, will continue to participate in the PbS system, and is working to better utilize this important tool.

¹¹ The Performance-based Standards (PbS) system was developed by the Council of Juvenile Correctional Administrators at the request of the Department of Justice to assist youth correction and detention facilities in continuously improving the conditions of confinement and the services provided. PbS is described as a tool that agencies can integrate into existing operations to develop, monitor, and sustain improvement. Details can be found at <http://www.performancebasedstandards.org>.

KEY FINDINGS

2. YSA's use of consultants has been largely ineffective and characterized by unauthorized overspending, incomplete deliverables, unfulfilled objectives, and poor agency oversight.

YSA has expended considerable human and financial resources in an ongoing attempt to comply with the provisions of the Decree. From 1998 through 2003, YSA paid approximately \$3.6 million to consultants in an effort to bring YSA into sustained compliance and to establish the foundation by which YSA would evolve into a best practices agency. Despite these efforts, the team found that conditions cited in reports by consultants continue to exist, and YSA has failed to effectively implement many of the recommendations provided.

a. YSA officials stated they could not locate important documentation such as contracts, purchase notifications, and major deliverables.

The team found significant gaps in documentation of YSA's use of consultants. For example, officials could not provide the team with a 1998 contract through which a consultant was paid \$155,000 to develop an "Implementation Plan" for YSA management reform. Officials also were unable to locate key milestone deliverables referenced in a number of consulting contracts, such as reports assessing various aspects of agency operations and associated recommendations. Officials could not provide the team with any contract deliverables related to their most recent engagement of a consultant for a \$412,000 "agency advancement" project that spanned from December 2002 to July 2003.

b. The timeframes of several consulting contracts were unrealistic given their ambitious and wide-ranging scope of work.

Between April 1998 and October 1998, YSA utilized a juvenile justice consulting company to develop and implement a plan for "YSA Management Reform," at a cost of approximately \$622,000. A review of the contract found that within this 7-month period, the consultant agreed to provide primary analysis, planning, recommendations and program management services in the following areas:

- identification of OHYC facility improvements;
- development and implementation of revised agency policies and procedures;
- improvement of YSA's organizational structure, work processes, and staffing;
- improvement of YSA's Management Information System (MIS) and provision of MIS training;
- development of a case management program whereby the needs of each youth are assessed (and reassessed as required) and steps are taken to ensure that the requisite services are provided;
- implementation of an internal financial management system that enables administrators to access statistics that measure cost effectiveness of agency programs and operating practices;¹²

¹² This system was to provide a means for financial control, inventory and warehouse tracking, and performance tracking against budgets.

KEY FINDINGS

- development and implementation of an effective management system for the entire spectrum of youth residential and treatment options;
- provision of recommendations for redefining YSA's position in the overall government structure of the District;
- provision of agency planning and forecasting; and
- provision of data and processes necessary to begin benchmarking YSA's performance.

The scope of the contract deliverables was extremely unrealistic given the short period of the contract. As a result, the contractor did not provide many of the services listed above, which led to unrealized project goals and, consequently, to YSA's need to acquire additional consulting services.

c. A consultant was paid in excess of contract funding limits despite the lack of deliverables.

The team reviewed invoices related to the above-referenced consulting contract. The implementation phase of the contract was from June 1998 through October 1998, and the contract stipulated that the funding level for implementation of the plan was not to exceed \$466,533. By September 28, 1998, however, the consultant had already invoiced YSA in excess of the contract's stipulated funding level even though the majority of the deliverables had not been completed. The team's analysis of the consultant's invoices revealed that 18 of 31 contract deliverables were less than 70% complete on September 28, 1998.

d. YSA used unauthorized purchase notifications to circumvent the spending and term limits on consultant contracts.

The team reviewed the payment history and invoices related to the aforementioned 1998 contract and found that YSA approved work and payments to the consultant in 1999 even though the contract expired in October 1998. The team requested documents from YSA, OCP and DHS, but could not find an authorization to extend the contract beyond October 1998. YSA paid this consultant an additional \$143,000 between November 1998 and June 1999.

The team found that YSA circumvented the spending limit and time frame of the contract through the use of purchase notifications that were not signed or approved by an OCP contracting officer. Therefore, there was no indication that YSA was authorized to exceed the stipulated spending and term limits of the contract.

e. YSA paid a consultant approximately \$1.25 million between 1999 and 2001 in large part to improve the agency's information management system, yet the consultant never delivered basic system capabilities enumerated in the statement of work.

The team found that this consultant was required to design and implement a new Information Technology (IT) infrastructure for YSA. The infrastructure was to have the ability to generate various statistical reports on YSA's youth population and agency administration,

such as daily population summaries, weekly admissions and releases, monthly statistical and case management summaries, and court appearance lists.

The consultant failed to provide deliverables stipulated in the contract, and YSA eventually retained the services of another consultant in an attempt to implement an effective IT infrastructure. The team found, however, that YSA's IT system still does not have the capability to generate basic statistical reports. (*See Finding 17*)

From January 2001 through July 2003, YSA paid two consultants approximately \$1.4 million to develop and implement an “Agency Advancement Plan,” to serve as the programmatic guide to establish and maintain YSA’s juvenile justice system consistent with the Decree. Both consulting companies were based in Oklahoma and costs related to travel and accommodations accounted for over 20% of the direct costs incurred during the contract periods.

A review of quarterly status reports found that the consultants performed basic administrative tasks while at YSA. Consultants traveled to YSA and routinely re-organized paper files, filed documents, reviewed placement logs for basic data, and audited youth case files to collect Decree compliance data.

Administrative tasks performed by the consultants duplicated the efforts of the court appointed monitor. Case file review and Decree compliance auditing are a significant part of the court monitor's responsibilities for which YSA pays approximately \$150,000 annually.

That the A/YSA, in order to minimize the duplication of previous efforts, coordinate a review and prioritization of all policies, procedures, assessments, and recommendations produced by past consultants, and identify those deliverables that can be salvaged and implemented.

Agree **X** Disagree

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. As part of her mandate to initiate management infrastructure reform, the Interim A/YSA will "coordinate a review and prioritization of all policies, procedures, assessments, and recommendations produced by past consultants, and identify those deliverables that can be salvaged and implemented." Later in these responses, DHS/YSA agrees to a recommendation to review prior contracts recognizing that most of the YSA officials involved with these contracts are no longer employed by the government. Once the Deputy Administrator for Support Services (Chief Administrative Officer) is in place, YSA would like to meet with the

KEY FINDINGS

inspection team to review the OIG's factual findings in detail to determine whether further corrective action is indicated.

3. Illegal substances such as marijuana and PCP are smuggled into OHYC regularly.

According to YSA officials, nearly 100% of OHYC youths suffer from substance abuse problems. The Decree requires YSA to provide treatment programs to assist residents in recovering from these problems. The availability of illegal substances such as marijuana and PCP in OHYC hinders treatment and recovery of residents with pre-existing substance abuse problems.

A number of OHYC employees and substance abuse treatment counselors interviewed by the team stated that the presence of illegal substances has been an ongoing problem for a number of years. The team reviewed a random sample of drug test results and found that numerous residents who tested negative for drug use upon arrival at OHYC also tested positive for marijuana and PCP after being confined (see table next page).

OHYC employees and substance abuse treatment counselors stated that Youth Correctional Officers (YCOs) are a primary source of the illegal substances used by youths in OHYC, and that the lack of proper security checks at the entrance has allowed them, and presumably others, to carry in contraband past the security guards. YSA has taken measures to upgrade the OHYC security force, and that action should improve the detection of contraband (such as illegal drugs) at OHYC entrances. However, OIG recommends that YSA take additional actions such as instituting a canine drug detection program, to prevent the entry of illegal substances into OHYC.

A Management Alert Report (MAR 03-I-011 at Appendix 2) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 3. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR.

KEY FINDINGS

Youths Test Positive for Drugs After Detention in OHYC

The data in this table is taken from OHYC drug testing records. A sampling of individual records shows that many youths who tested negative when they arrived at the facility tested positive weeks later for illegal substances, particularly marijuana. For example, Youth A was tested on June 5, 2003, shortly after arrival and tested negative for illegal substances. On June 30, 2003, however, the same youth tested positive for opiates, cocaine, marijuana, and PCP.

| Youth | Date | Opiates | Cocaine | Marijuana | PCP |
|----------|---------|---------|---------|-----------|------|
| A | 6-05-03 | None | None | None | None |
| | 6-30-03 | 800 | 1579 | 63 | 235 |
| | 7-25-03 | None | None | 54 | None |
| | 7-30-03 | None | None | 121 | None |
| B | 5-27-03 | None | None | None | None |
| | 6-05-03 | None | None | None | None |
| | 6-19-03 | None | None | None | None |
| | 7-23-03 | None | None | 56 | None |
| | 7-29-03 | None | None | 111 | None |
| C | 7-10-03 | None | None | None | None |
| | 7-30-03 | None | None | 121 | None |
| D | 3-11-03 | None | None | None | None |
| | 4-10-03 | None | None | 300 | None |

Note: The numbers listed in the columns beneath the various illegal substances represent the nanograms of the substance found in the youth's urine.

KEY FINDINGS

Recommendations:

- a. That the A/YSA request that the DHS Office of Investigations and Compliance (OIC) investigate allegations by staff members that YCOs are transporting illegal substances into OHYC. The Director of DHS should report the results of that investigation to the Inspector General, and to other government entities as may be required by District, Maryland, or federal law.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In connection with MAR 03-I-011, the Interim A/YSA requested, through the DHS Director, that DHS/OIC investigate allegations by YSA staff members that YCOs are transporting illegal substances into OHYC.

- b. That the A/YSA explore the feasibility of implementing a canine drug detection program for illegal substances at OHYC.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with each of OIG's factual findings. YSA has explored the feasibility of working with the D.C. Metropolitan Police Department (MPD) and the D.C. Department of Corrections (DOC) to use the OHYC as an extension of their respective canine training programs to buttress YSA's drug interdiction measures inside of the facility. MPD already has visited OHYC on three separate occasions and DOC is expected to have similar capabilities within two months. YSA is working with MPD and DOC to implement a permanent canine drug detection program for illegal substances at both OHYC and YSC.

4. OHYC does not have a substance abuse treatment program as required by the Decree and is in jeopardy of failing to qualify for federal grant funding.

OHYC has been without a structured substance abuse treatment program since March 2003. Prior to that date, a vendor provided a substance abuse treatment program called Substance Abuse Free Environment (SAFE). The team found the vendor chose not to seek renewal of its contract because OHYC could not provide an environment conducive to producing positive therapeutic results. They specifically cited OHYC's inability to curtail the influx of illegal substances as a major factor in their decision.

The Decree mandates at page 21 that "[a]dequately trained and a sufficient number of personnel will be available at the facilities to provide drug educational and counseling services,

KEY FINDINGS

as needed based on the [youth's individual service plan]....” As a result of not having a substance abuse treatment program, YSA is in violation of the Decree, and youths in need of treatment are denied this vital service. In addition, OHYC may be eligible to receive funding for a substance abuse treatment program through the Residential Substance Abuse Treatment (RSAT) program¹³, a federal grant awarded by the U.S. Department of Justice. However, without a substance abuse treatment program in place, YSA is not eligible to apply for funds from this grant.

The team found that various OHYC social service and mental health employees are currently providing limited substance abuse counseling and education to youths. However, these employees stated that the education and counseling they provide are not an adequate replacement for the comprehensive treatment program previously provided by the certified substance abuse treatment counselors through the SAFE program.

Recommendation:

That the A/YSA expedite the procurement of a contract to provide drug educational and counseling services as required by the Decree and ensure that YSA is eligible to apply for the federal grant funding.

Agree **X** Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. For example, YSA specifically disagrees with the statement in the previous section that, “[a]ccording to YSA officials, nearly 100% of OHYC youths suffer from substance abuse problems.” YSA recently tested 159 youth and only 14 or 8.8% tested positive for the presence of illegal substances (i.e. cannabinoids). Nevertheless, YSA considers drug educational and counseling services to be a top priority. In March 2002, the D.C. Office of Contracting and Procurement (OCP) issued RFP No. PO-JA-2002-R-0037, which was designed to obtain proposals to establish a therapeutic community treatment approach to treat the substance abuse problems of youth committed to the OHYC. The RFP was modified several times and, in its final version, requested that the successful offeror provide YSA with substance abuse services for 20 committed youth at OHYC with a 1:10 treatment staff-to-youth ratio using the therapeutic community treatment approach. YSA reassessed its needs and decided to seek substance abuse services for 40 committed youth at OHYC, to require a 1:5 treatment staff-to-youth ratio, and to recommend a Cognitive Behavioral approach. Accordingly, OCP cancelled RFP No. PO-JA-2002-R-0037 and issued a new solicitation incorporating YSA's reassessed requirements. Twelve potential offerors met with procurement officials in late February 2004 to discuss the program requirements.

¹³ RSAT assists states in developing and enhancing drug treatment for offenders. Grant-supported programs must be 6 to 12 months in duration. Treatment participants must reside apart from the general inmate population. Funding received from the RSAT program is administered and distributed by the D.C. government's Office for Public Safety and Justice, Justice Grants Administration division.

KEY FINDINGS

5. Contract security guards allowed serious security breaches at entrances to the OHYC Detention Facility.

During most of the period covered by this inspection, a private firm contracted by the District's Office of Contracting and Procurement (OCP) provided security at OHYC entrances. The Office of Property Management's (OPM) Protective Services Division was responsible for monitoring security services under this contract. Because the security guards were hired through OCP and monitored by OPM, YSA management exercised no direct supervision over the guards. According to YSA management, neither OCP nor OPM adequately monitored the performance of the security guards. The contract did not permit YSA management to take disciplinary action against guards who violated security policies and procedures, even when an infraction was fully documented.

The duties of the contracted security guards were to:

- prevent the entrance of contraband¹⁴ into the detention facility through the use of effective package searches, metal detector screenings, and frisks or pat searches; and
- control the perimeter of the facility by preventing unauthorized persons and/or vehicles from entering the facility by obtaining proper identification and registering all non-YSA employees and vehicles.

A Management Alert Report (MAR 03-I-007 dated October 9, 2003) alerted District officials to significant problems in security at OHYC, and a number of these problems were attributed to the poor performance of the contract security officers. The MAR and management's response, which contains plans for addressing these problems, are at Appendices 4 and 5. In November 2003, the City Administrator replaced the contract security force with officers from the District's Department of Corrections. It is not clear at this writing if this change will be permanent.

Although the findings and recommendations in this section were developed when the security force was contractual, they remain relevant because some security problems, such as careless searches, inadequate frisk and pat procedures, and inadequate background checks, have not yet been resolved. In addition, this information can be evaluated and used by YSA as lessons learned, and is applicable to establishing an effective permanent security operation with a new group of security personnel.

¹⁴ YSA defines contraband as articles, prohibited under law applicable to the general public, that are readily capable of being used to cause death or serious physical injury, such as firearms, cartridges, knives, explosives, or illegal drugs. These items are prohibited by the rules and regulations of the facility and, when possessed by a resident without authorization, are considered contraband and are seized.

KEY FINDINGS

a. Inadequate searches by security guards allowed the entrance of contraband items, including illegal substances, into the secure detention facility.

YSA management has posted signs at the entrance of OHYC advising visitors and employees that all packages are subject to search. A list of contraband items that are not permitted in the facility is posted at the same entrance. The team found, however, that the security guards were performing only cursory searches of items, such as bags, briefcases, and purses, brought into the facility by staff and visitors. On numerous occasions, the team observed the security guards failing to open and search these items. As a result, staff stated that contraband - - including cell phones, non-prescription drugs (such as marijuana and PCP), cigarettes, lighters, videotapes, knives, items that could be used as weapons (such as ice picks), and pornographic materials - - have gone undetected through the security checkpoint. Consequently, a number of residents have tested positive for illegal substances during random drug testing.

b. Security guards did not always use the metal detector at the gatehouse.

ACA recommends the use of metal detectors at entrance gates. YSA uses a walk-through metal detector similar to those found at airports. Employees and visitors are required to walk through the metal detector prior to entering the secure facility.

On numerous occasions, the team observed that security guards failed to activate the metal detector, and visitors walked through unchecked. Also, visitors and employees were not required to take bags, purses, briefcases, or packages through the metal detector. As a result, unchecked or inadequately searched bags containing guns, knives, or metal objects that could be used as weapons could be carried into the facility with their contents undetected.

c. Security guards were not using effective frisk or pat search procedures on employees and visitors.

All visitors are advised that they will be subject to a frisk or pat search of their clothing prior to entering the facility. The Deputy Administrator stated that all employees are also subject to a frisk or pat search.

The team found that security guards conducted only cursory searches by lightly running their hands over the shoulders, arms, sides of the body, and the sides of legs of those who enter the facility. Security guards also did not require visitors or employees to empty their pockets when items that might be questionable were detected. Often, there was no frisk or pat down of any visitor or employee.

Security guards stated that they did not have correctional facility backgrounds, had not been provided written guidelines for conducting frisk or pat searches, and had not been trained by either the security company or YSA. Several security guards stated that former employees provided only verbal instructions on the frisk and pat search procedures.

d. Control of pedestrians and vehicles entering the front gate was inadequate and

ACA standards recommend that pedestrians and vehicles enter and leave a secure facility at designated points on the perimeter. Those designated points should be controlled by appropriate means to prevent unauthorized access.

The inspection team found that on numerous occasions, there was no security guard present at this entrance, and the security gates had been left open and unattended because the guard left to use a restroom located across the street from the entrance. (Restroom facilities inside the front gate security trailer had been out of service since 2001.) On other occasions, the team observed the security guard sitting in the guard trailer, using the telephone, and allowing vehicles to enter and exit the open security gate at will.

Recommendations:

- Agree **X** Disagree

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. These factual findings appear to contemplate use of a contractor for security services. DHS/YSA is working with the Department of Corrections (DOC) under the terms of a Memorandum of Understanding (MOU) to "provide adequate policies, procedures, and training for security guards to ensure that proper searches of all bags and packages of visitors and employees entering the secure detention facility are conducted."

- Agree **X** Disagree

KEY FINDINGS

DHS's Response to IG's Recommendation, as Received:

DHS/YSA is working with DOC under the terms of a MOU to "provide adequate policies, procedures, and training for security guards to ensure that effective frisk and pat search procedures are conducted on visitors and employees entering the secure detention facility."

- c. That the A/YSA ensure that the gatehouse metal detector is operational and in use at all times.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

YSA is seeking to replace the non-operational gatehouse metal detector and will thereafter "ensure that the gatehouse metal detector is operational and in use at all times." YSA is using grant funds in FY 2004 for this purpose.

- d. That the A/YSA ensure that at least two security guards are present at the perimeter entrance gate and that guards adhere to all entrance security procedures.

Agree _____ Disagree _____ **X** _____

DHS's Response to IG's Recommendation, as Received:

DHS/YSA is working with DOC under the terms of a MOU to provide perimeter security for OHYC. The applicable ACA standards do not require two security personnel at the perimeter entrance gate. Rather, DOC provides a single officer for the perimeter entrance gate with a relief officer. YSA believes that the current staffing for this post is appropriate given its limited function (i.e. essentially a checkpoint) and other security measures in place at specific destinations on the grounds.

OIG Response: Actions planned and taken by YSA should adequately address the conditions noted.

- e. That the A/YSA take immediate action to have the front gate restroom facilities repaired so that guards will not have a reason to leave the post unsecured.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

YSA has repaired the previously non-operational front gate restroom facilities referenced in this section.

6. **YSA does not conduct adequate and timely background checks on those who must have regular contact with youths.**

KEY FINDINGS

ACA standards and best practices suggest that a criminal background check be conducted on all employees who would have regular contact with youths. Although YSA is not required by District law to conduct such checks, an internal policy has required them since 1999. Prior to that year, background checks were neither required nor routinely conducted.

a. A number of current employees working closely with youths have not undergone background checks.

The team reviewed 30 randomly selected personnel files of employees who work with youths at OHYC. Fifteen files were for employees hired since 1999, and 10 of the 15 (66%) did not contain verification that a background check had been conducted. None of the files reviewed for employees hired prior to 1999 contained background check information. According to the Human Resources Manager, no effort has been made to conduct criminal background checks on current employees hired prior to 1999.

b. Background checks are limited to a search of Metropolitan Police Department (MPD) records.

Current and potential OHYC employees reside not only in the District, but also in Maryland and Virginia. Consequently, best practices suggest that in addition to YSA's limited MPD records search, background checks should include surrounding law enforcement jurisdictions, as well as the Federal Bureau of Investigation's National Crime Information Center (NCIC). YSA also does not review the Central Registry of Crimes Against Children/Sex Offenders as part of its background check.

YSA's Human Resources Manager stated that because YSA is not a law enforcement agency, it does not have direct access to the NCIC, and attempts to have NCIC checks conducted by MPD on behalf of YSA have failed because of funding issues.

Without adequate background checks on all employees who must interact routinely with youths, YSA may unknowingly hire or have currently employed individuals with a history of violence, abuse, or other criminal behavior that could endanger the youths entrusted to their care. This creates an unnecessary and unacceptable risk to OHYC youths, their families, and the District government.

Recommendations:

- a. That the A/YSA ensure that all current employees with regular contact with youths and all applicants undergo a MPD criminal background check as required by current policy.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

The Interim A/YSA will “ensure that all current employees with regular contacts with youths and all [successful] applicants undergo a MPD criminal background check as required by current policy” and in connection with current emergency and temporary legislation.

- Agree **X** Disagree

The DHS Director notes that current emergency and temporary legislation already is in place and has been the subject of hearings before the Council of the District of Columbia.

YSA maintains a fleet of buses, passenger vehicles, and trucks to transport residents and supplies, and for general maintenance activities at YSA facilities.

It shall be unlawful for any person to operate, park, or permit to be operated or parked on public space any vehicle bearing current District of Columbia tags, except a vehicle exempt under the provisions of § 602.3,¹⁵ unless there is displayed on the right side of the vehicle's windshield one of the following:

- During an inspection of the YSA motor pool, the team observed 10 vehicles with either no inspection stickers or expired stickers. As a result, the team obtained a list of all vehicles assigned to YSA, and documented 32 of 62 YSA vehicles with expired inspection stickers.

¹⁵ None of the exemptions listed in Section 602.3 apply to this issue.

KEY FINDINGS

order to prevent employees from driving them. However, management indicated that some employees continued to operate these vehicles outside of the OHYC compound in violation of District regulations.

The team also noted that 26 of 62 vehicles had not received semi-annual preventive maintenance (PM) checks as required by the Department of Public Works (DPW), Fleet Management Administration (FMA). The FMA manual states at page 87, “all vehicles will be scheduled at least semiannually for [PM inspection].” In addition, FMA policies state that “the [r]epeated failure to comply with PM inspection schedules may result in a restriction of vehicle use and/or the refusal of fuel.”¹⁶ *Id.* at 89.

YSA managers stated that only one DPW mechanic is available 2 days per week to service the entire fleet of YSA vehicles at OHYC. Consequently, the mechanic cannot adequately service YSA vehicles in a timely manner, thereby delaying necessary vehicle repairs and maintenance.

A Management Alert Report (MAR 03-I-006, Appendix 6) addressing these issues was sent to the A/YSA. A copy of the A/YSA’s response to the MAR is at Appendix 7. The team will follow-up on the A/YSA’s progress in correcting the problems cited in the MAR.

Recommendations:

- a. That the A/YSA ensure that all vehicles are properly inspected in accordance with District Municipal Regulations.

Agree X Disagree _____

DHS’s Response to IG’s Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG’s factual findings.

- b. That the A/YSA discontinue the use of vehicles that do not contain valid inspection stickers.

Agree X Disagree _____

DHS’s Response to IG’s Recommendation, as Received:

¹⁶ Pursuant to Mayor’s Order 2000-75, the Department of Public Works, Fleet Management Administration is responsible for maintaining the fleet management program of the District government. This includes vehicle maintenance, repair, and replacement for all District agencies. However, the agency heads of the Metropolitan Police Department, Department of Corrections, and Fire and Emergency Medical Services may, at their discretion, continue to procure, acquire, maintain, repair, and dispose of non-emergency vehicles and motor equipment used by their agencies.

KEY FINDINGS

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- c. That the A/YSA ensure that semi-annual preventive maintenance checks are conducted on all YSA vehicles.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- d. That A/YSA coordinate with DPW to either increase staffing levels for mechanics assigned to OHYC or allot additional days per week for the DPW mechanic to service and maintain YSA's fleet of vehicles.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

8. YSA employees are operating government vehicles without valid state driver's licenses and government motor vehicle identification cards.

Title 18 DCMR § 100.2 states

[n]o person, except those expressly exempted by § 100.3,¹⁷ shall drive any motor vehicle in the District of Columbia unless he or she has a valid license under the provisions of this chapter.

In addition, YSA Policy Number 9.11, Section V(A)(3) (2000), states :

All employees must possess a valid state driver's license from D.C., Maryland or Virginia, to operate a District owned or leased vehicle, and all employees must possess and maintain on their person, a valid D.C. Government Motor Vehicle Driver Identification Card.

Documentation provided by YSA management disclosed that 32 YSA employees authorized to drive District vehicles had not provided validation of their state licenses and D.C. Government Motor Vehicle Driver Identification Cards. Also, additional documentation

¹⁷ These exemptions do not apply to this issue.

KEY FINDINGS

disclosed that 38 employees had expired D.C. Government Motor Vehicle Driver Identification Cards.

A Management Alert Report (MAR 03-I-006, Appendix 6) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 7. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR.

Recommendation:

That the A/YSA ensure that all vehicle operators maintain current state driver's licenses and D.C. Government Motor Vehicle Identification Cards.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree OIG's factual findings.

9. YCOs and transportation officers lack adequate communication equipment.

YCOs' primary responsibilities are to provide security and supervision within the various educational, recreational, treatment, and residential buildings, and to escort youths between buildings in the OHYC secure area. YCOs use a centrally located office in each housing unit to store equipment, process paperwork, and complete other routine tasks.

Transportation officers escort youths from OHYC to D.C. Superior Court on "court buses," and transport youths to treatment facilities within the metropolitan area using passenger vans.

- a. A number of YCOs do not have two-way radios that would enable them to communicate with OHYC's security control office. This jeopardizes their safety and compromises overall security.***

The team noted that many of the YCOs on duty in the housing units were not carrying two-way radios. They stated that often there is only one radio available within each housing unit¹⁸ even though there are two or more officers assigned to the unit. The team also observed YCOs without two-way radios in areas other than the housing units, escorting and supervising youths. The team observed several radios in poor condition. One radio appeared to be held together with clear tape, while another was bound with rubber bands. YCOs stated that the two-way radios do not have clear, audible reception, rendering them useless in an emergency.

¹⁸ OHYC housing units 7, 8, 9, and 10 each have an "A" unit and a "B" unit. When using the term "housing unit," the inspection team considers, for example, Units 7A and 7B to be two separate housing units.

KEY FINDINGS

The quantity and condition of the two-way radios represent a potentially significant threat to the safety of the YCOs, especially those working in the housing units. If there is only one two-way radio in a unit, and the officer carrying that radio is involved in an altercation during which the radio is damaged or inaccessible, other officers on duty may be unable to quickly request and receive assistance. In that scenario, an officer would have to reach the nearest available hard-wired telephone.

b. The hard-wired telephones located in some YCO offices in the housing units are inoperative.

The team found that a number of hard-wired telephones in the housing unit security offices used by YCOs were inoperative, and in Unit 6 where females are detained, the telephone was missing. During a visit to one unit in September 2003, YCOs on duty stated that the telephones had been out of service since June 2003, and they did not have access to another telephone.

c. An inadequate number of telephones for youths' personal calls contributes to security risks in the housing units.

The YCO office should be off-limits to youths at all times and the phone should be for staff use only. This ensures reliable communication should radios be unavailable and minimizes the possibility that youths could disable the telephone prior to or during an altercation or escape attempt.

As stipulated in the Decree, "children are entitled to two telephone calls per week of ten minutes each" and "telephones will be located on each living unit."¹⁹ The team found that the number of telephones available for these calls in the living units is insufficient. As noted above, YCOs in one unit stated that the telephone had not worked since June 2003, and YCOs were not providing youths with their biweekly calls from a telephone in their living unit, as stipulated in the Decree.

According to several YCOs, often the only phones available for these calls are in the YCO offices. On one occasion the team observed a youth using the telephone in a YCO office.

d. When transporting youths outside of OHYC, transportation officers, who must maintain security and report incidents, are not issued government radios or cellular telephones, and cannot maintain regular contact with the OHYC security control office.

The three to four transportation officers, who escort youths between OHYC and D.C. Superior Court and other locations, are not given government-issued telephones or radios. They often use their personal cellular telephones to communicate with the OHYC security control office, even though they are not reimbursed for the calls.

¹⁹ A case manager, or in his/her absence a YCO, must place all calls for the youths.

KEY FINDINGS

At least one of the transportation officers should have reliable communication equipment, either a cellular phone or two-way radio, in order to communicate with the OHYC security control office or public safety agencies (such as the Metropolitan Police Department) in the event of an emergency.

A Management Alert Report (MAR 03-I-008 at Appendix 8) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 9. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR.

Recommendations:

- a. That the A/YSA ensure that each YCO on-duty at OHYC has a functional two-way radio for the duration of his or her shift.

Agree _____ Disagree X

DHS's Response to IG's Recommendation, as Received:

The DHS Director noted in her response to MAR 03-I-008 that 25 additional two-way radios were purchased and that these radios were assigned to each housing unit so that YCOs on duty have access to radios.

OIG Response: **Actions planned and taken by YSA should adequately address the conditions noted.**

- b. That the A/YSA ensure that wired telephones are repaired or replaced so that the YCO office in each housing unit has a working telephone.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The DHS Director noted in her response to MAR 03-I-008 that YSA, in conjunction with DHS's Deputy Director's Office, the Office of the Chief Technology Officer (OCTO), and Verizon Communications, "completed a thorough assessment regarding the telecommunications needs of YSA and they are in the process of establishing a corrective action plan." The Interim A/YSA will take action in accordance with the corrective action plan.

- c. That the A/YSA provide additional telephones in each housing unit (i.e., a phone other than the one in the YCO office) to accommodate the youths' biweekly telephone calls.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The DHS Director noted in her response to MAR 03-I-008 that YSA, in conjunction with DHS's Deputy Director's Office, OCTO, and Verizon Communications, "completed a thorough assessment regarding the telecommunications needs of YSA and they are in the process of establishing a corrective action plan." The Interim A/YSA will take action in accordance with the corrective action plan.

- Agree **X** Disagree

Agree **X** Disagree

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The DHS Director noted in her response to MAR 03-I-008 that YSA, in conjunction with DHS's Deputy Director's Office, OCTO, and Verizon Communications, "completed a thorough assessment regarding the telecommunications needs of YSA and they are in the process of establishing a corrective action plan." The Interim A/YSA will take action in accordance with the corrective action plan.

The team interviewed social services staff members and noted that not all of the TTLs and SSRs have telephones in their unit offices and/or functioning mailboxes on the facility's voicemail system. Social services employees who do not have a telephone in their unit office must either use the telephone in another unit or rely upon their personal cell phones. Similarly,

KEY FINDINGS

those social services employees who lack voicemail capability either use their personal cell phones or instruct callers to dial the social services office main phone number and leave a message with the person who answers.

The TTLs and SSRs provide a vital link between OHYC youths and various agencies and service providers located both within the facility and in the community. These employees also provide critical, time sensitive information and updates to family members and off-site caseworkers. The lack of a telephone or an inoperable voice mailbox impedes an employee's ability to provide responsive care and efficiently interact with all parties that participate in a youth's treatment and rehabilitation.

A Management Alert Report (MAR 03-I-008 at Appendix 8) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 9. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR.

Recommendation:

That the A/YSA ensure that employees in the Social Services department (TTLs, SSRs, and their supervisors) have functioning telephones and voice mailboxes.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The DHS Director noted in her response to MAR 03-I-008 that YSA, in conjunction with DHS's Deputy Director's Office, OCTO, and Verizon Communications, "completed a thorough assessment regarding the telecommunications needs of YSA and they are in the process of establishing a corrective action plan." The Interim A/YSA will take action in accordance with the corrective action plan.

11. Inadequate security equipment in the female housing unit impedes YCOs' effectiveness and creates potential hazards.

YSA houses committed²⁰ and detained²¹ female residents in a separate housing unit (Unit 6). Unit 6 is in an isolated area approximately one mile from the OHYC security control office. The team observed serious deficiencies that impair the ability of YCOs to effectively maintain the safety and security of female residents and to ensure their own safety as well.

a. Unit 6 has only one two-way radio for use by five security officers.

²⁰ A commitment or "committed youth" is defined as a juvenile court disposition ordering an adjudicated delinquent be held, for a definite period of time in the state's delinquency agency, typically in a training school or other secure institution.

²¹ A detainment or "detained youth" is defined as the temporary custody of juveniles who are accused of a delinquent act and require a restricted or secure environment for their own or the community's protection while awaiting a final court disposition.

KEY FINDINGS

Unit 6 has five YCOs on duty who provide security and supervision of female residents. They escort residents from the unit to medical appointments, court appearances, and the main secure detention facility. However, the YCOs on duty in this unit must provide 24-hour security with only one two-way radio. YCOs stated that often the radio malfunctions, leaving them unable to communicate with the security control center.

The lack of a sufficient number of two-way radios and the poor condition of the one radio on hand represent a significant threat to the safety and security of the YCOs and residents. For example, if there were an altercation or other disturbance at Unit 6, residents and YCOs alike would be at risk of sustaining serious injuries that might be avoided if the YCOs have an adequate number of properly functioning radios with which to summon immediate assistance.

b. There is no telephone in the Unit 6 security office.

It is critical that each YCO office in each housing unit has functioning telephones as backup to the two-way radios in case the radios malfunction and there is an immediate need for assistance.

The Unit 6 security office is not equipped with a telephone and YCOs must rely solely on two-way radios for communication. A backup telephone system is particularly important in the YCO office at Unit 6 where there was only one two-way radio as discussed above.

c. The electronic security monitoring system in Unit 6 is inoperative, and the facility's exterior lighting is inadequate.

YSA Post Orders dated May 1992 state, "[Correctional staff are] [t]o make sure that all Electronic Security Systems are on-line, operational[,] and report all malfunctions to a [Supervisor]...[T]he malfunction and actions taken shall be recorded in the Log Book."

Although Unit 6 has security monitoring equipment in the YCO office to provide real time viewing of the hallways, recreational areas, and day-to-day operations throughout the unit, the equipment is inoperative. The team found that several cameras used for electronic monitoring were outdated and performing inadequately. YCOs stated that much of the electronic security system has been inoperative for several years. The lack of adequate monitoring equipment prevents proper surveillance of the secured areas, and could allow residents to escape from the facility undetected.

YCOs also stated that the illumination provided by the exterior security lights in the parking area of the facility is inadequate. They fear that intruders could lie in wait in dark or inadequately lit areas around the building, and then assault them as they walk to their cars at the end of each shift.

d. The metal detector and hand wand at the entrance of the Unit are not always activated.

KEY FINDINGS

The ACA recommends the use of metal detectors at the facility's entrance. Unit 6 uses a walk-through metal detector similar to those found at airports, but it had not been activated when the inspection team visited. Unit 6 also has a hand wand to scan employees and visitors for metal objects, but the hand wand did not have batteries and was not being used. Consequently, visitors could bring contraband metallic objects, such as guns and knives, into the unit without detection.

e. The YCO security office's lack of air conditioning and heating creates uncomfortable working conditions.

ACA standards recommend that temperatures in living and work areas be appropriate to the summer and winter comfort zones, and that employees be able to mechanically raise or lower temperature and humidity to an acceptable comfort level. However, the team observed that there are no operating heating or air conditioning units in the YCO security office, which serves as the unit's command post. Consequently, YCOs often must tolerate either extreme heat or extreme cold on each shift.

f. YCOs are not issued proper uniforms.

YCOs are issued uniforms to wear while on duty. These uniforms should be suitable for both winter and summer months. Unit 6 YCOs stated that they have not received winter uniforms and are forced to wear summer uniforms that are inappropriate for the winter season. They further stated that their uniforms often are two and three sizes too large and must be altered at their own expense. Despite requests for seasonal and appropriately sized uniforms, YCOs stated that their requests have not been accommodated.

The cited deficiencies in the areas of communication, electronic monitoring, security lighting, metal detectors, and the work environment impede YCOs' ability to work effectively and efficiently, and create potential hazards for both YCOs and residents.

A Management Alert Report (MAR 03-I-009 at Appendix 10) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 11. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR.

Recommendations:

- a. That the A/YSA ensure that each YCO on duty in Unit 6 has a functional two-way radio for the duration of his or her shift.

Agree _____ Disagree X

DHS's Response to IG's Recommendation, as Received:

In response to MAR 03-I-008, the DHS Director advised OIG of certain new procedures to address communication equipment deficiencies at OHYC. In response to MAR 03-I-009, the Interim A/YSA issued four additional two-way radios to the Unit Supervisor in Unit 6. In the

KEY FINDINGS

event additional radios are necessary, the Officer of the Day will ensure that any staff member who needs access to a two-way radio receives this equipment immediately.

OIG Response: **Actions planned and taken by YSA should adequately address the conditions noted.**

- b. That the A/YSA ensure that a working telephone is installed in the YCO security office.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-008, the DHS Director advised OIG of certain new procedures to address communication equipment deficiencies at OHYC. In response to MAR 03-I-009, the Interim A/YSA issued four additional two-way radios to the Unit Supervisor in Unit 6. Please be advised that the telephone that was broken during the inspection team's visit to Unit 6 has been repaired and is operational.

- c. That the A/YSA ensure that an emergency buzzer, direct phone line, or other notification device is connected between Unit 6 and the OHYC security control center to provide an alternative means of immediate communication in the event of an emergency.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-008, the DHS Director advised OIG of certain new procedures to address communication equipment deficiencies at OHYC. In response to MAR 03-I-009, the Interim A/YSA issued four additional two-way radios to the Unit Supervisor in Unit 6. In the event additional radios are necessary, the Officer of the Day will ensure that any staff member who needs access to a two-way radio receives this equipment immediately.

- d. That the A/YSA ensure that all electronic security monitoring equipment is repaired or replaced.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-009, the Interim A/YSA advised that "YSA has repaired the electronic monitoring system in Unit 6."

KEY FINDINGS

- e. That the A/YSA ensure that YCOs keep the metal detector activated at all times, that batteries are installed in the hand scanner, and that the scanner is used in accordance with procedures.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-009, the Interim A/YSA advised as follows: "The metal detector and hand wand equipment at Unit 6 have been replaced. The equipment is operational and the staff has been instructed to have this security equipment operational at all times."

- f. That the A/YSA ensure the installation of adequate lighting for the exterior building perimeter.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-009, the Interim A/YSA advised as follows: "YSA is aware of the need to upgrade the facility's exterior lighting, and arrangements are being made to upgrade the electrical power so that institutional lighting can be enhanced for Unit 6."

- g. That the A/YSA ensure that sufficient air conditioning and heating are provided in the YCO security office.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-009, the Interim A/YSA advised as follows: "The heating and air conditioning ("HVAC") systems at Unit 6 are operational. However, due to the age of the HVAC system, there are no individual thermostats in the units that allow staff to regulate the temperatures in each unit. YSA currently is investigating ways in which we can provide facility enhancements that will address this situation."

12. The ratio of youths to YCOs exceeds Decree requirements.

The Decree states at page 13 that:

Sufficient numbers of trained and qualified cottage life staff shall be employed in each of the facilities to supervise youths at all

KEY FINDINGS

times. The ratio of cottage life staff to children shall be 1:10 at a minimum at all times that children are in the cottage or unit, except during normal sleeping hours.

Although two YCOs are assigned to each housing unit, the team observed that frequently only one YCO was on duty during the daytime. The team found that the Officer of the Day (OD) often reassigns YCOs from their original residential posts to provide security coverage in other areas of the facility. YCOs stated that consequently, they often work alone in the housing units, and must monitor 17-20 youths during the daytime, well beyond the 1:10 ratio required by the Decree. This not only violates the Decree, but also leaves YCOs unable to effectively monitor youth activities and ensure the security and safety of both the youths and themselves.

Recommendation:

That the A/YSA take the necessary steps to ensure compliance with the youth to YCO ratio.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. YSA recently hired additional YCOs and continues to recruit to fill vacancies in these positions at OHYC.

13. Serious fire safety deficiencies may put residents and employees at risk.

YSA policies and procedures state that fire hoses or extinguishers are to be available throughout OHYC; emergency evacuation plans must be posted publicly and fire drills are to be conducted on a quarterly basis.²² In order to meet OHYC's fire prevention and fire safety requirements, the YSA Health and Safety Officer must conduct monthly fire safety inspections of OHYC, and all inspection reports are to be kept on file and available for examination. In addition, the Health and Safety Officer must be knowledgeable of the District's 1996 Fire Prevention Code and the 1999 District of Columbia Construction Code Supplement.

a. Fire extinguishers were not accessible, fire drills were not being conducted, and emergency evacuation plans were not posted in key areas.

Fire extinguishers were not readily accessible to staff members and residents. YCOs assigned to various security posts throughout OHYC did not have keys to access fire extinguisher lock boxes in the event of an emergency. Fire extinguishers in the gymnasium were locked in a closet and were not readily accessible. According to the Recreation Specialist,

²² YSA Administrative Issuance No. 4-004, Part III- Facility Operations and Management, Chapter 4- Safety and Environmental Health. This document establishes policies and procedures for the safety programs, inspections, and fire and evacuation plans for institutional and community based residential facilities within YSA, including OHYC.

KEY FINDINGS

these extinguishers had been removed from the wall mounts to prevent residents from tampering with them.

The team also found that mandatory quarterly fire drills were not being conducted and emergency evacuation plans were not posted in every OHYC building. The team reviewed weekly fire inspection reports for the previous 6 months, but did not find any documentation or notes showing that quarterly fire drills had been conducted in the residential housing units. According to the Facilities Maintenance Foreman and other OHYC employees, fire drills are rarely conducted. The team found that the last documented fire drill was conducted on February 27, 2002.

Although YSA policy does not require that an emergency evacuation plan be posted at every location, the team found that many key locations at OHYC - such as classrooms, vocational buildings, and the gymnasium - lacked posted emergency evacuation plans.

b. OHYC does not have a trained Health and Safety Officer to conduct fire safety inspections.

OHYC does not employ a Health and Safety Officer who is knowledgeable of the District's 1996 Fire Prevention Code and the 1999 District of Columbia Construction Code Supplement.²³ Rather, an untrained OHYC maintenance employee currently performs weekly fire safety inspections in conjunction with his other assigned duties. Without proper training, however, this employee cannot ensure that such inspections are conducted in accordance with the fire and construction codes referenced above, and therefore cannot ensure the safety of residents and employees of OHYC.

The team reviewed a District of Columbia Fire and Emergency Medical Services Department (FEMS) Fire Prevention Bureau fire safety inspection report dated October 8, 2003. The report documented 88 fire safety deficiencies requiring immediate abatement. The team conducted an informal review based on the FEMS report and noted that as of November 19, 2003, 20 of the 88 deficiencies had not been abated because parts for repairs had not yet been received.

The lack of a trained Health and Safety Officer knowledgeable about fire safety and construction codes likely resulted in OHYC's inability to detect and correct fire hazards documented by FEMS during its fire safety inspection.

c. The locks on housing unit doors are manual and could pose a safety hazard in the event of a fire or other emergency.

During an inspection of the housing units for males and females, the team noted that the doors to residents' rooms have manual locks that require the use of a key. In addition, the Modular Housing Units' doors have dead bolt locks with the locking mechanism located on the

²³ The District of Columbia FEMS, Fire Prevention Bureau uses the Fire Prevention Code and Construction Code Supplement to ensure fire safety compliance.

KEY FINDINGS

outside of the doors. In each location, one of the YCOs assigned to the housing unit must manually unlock the doors in order for residents to enter or exit their rooms. There is no other method for unlocking or securing the doors.

In the male housing unit, the team found only 1 set of keys for each of the 20 resident rooms in each housing unit, although there were 2 YCOs assigned to each unit. In the female housing unit, only two of the five YCOs had keys to the individual rooms. In the event of a fire emergency or disturbance, these conditions could pose a safety hazard to both youths and YSA personnel if the YCOs are unable to unlock all doors in a timely manner.

The inaccessibility of fire extinguishers, lack of quarterly fire drills, lack of posted emergency evacuation plans, and the inability to conduct adequate fire inspections may result in serious injury to youths and employees in the event of a fire emergency. Additionally, without a centrally operated system to lock and unlock doors, the failure to provide all YCOs with keys to resident rooms endangers the safety of youths and YSA employees.

A Management Alert Report (MAR 03-I-010 at Appendix 12) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 13. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR.

Recommendations:

- a. That the A/YSA ensure that all employees have access to fire extinguishers at all times.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 0-I-010, the Interim A/YSA advised as follows: "YSA follows American Correctional Association ("ACA") standards pertaining to ensuring the safety and well being of its residents and staff at OHYC. To that end, all fire extinguishers are concealed in locked wall areas on each unit. The unit manager and supervisory youth correctional officer on each unit have keys to open the locked wall boxes. In order to provide additional safety measures to each housing unit, YSA will install a lock box in each of the security office's to ensure that the keys are available on the unit should a fire emergency occur."

- b. That the A/YSA ensure that the fire extinguishers in the gymnasium are removed from the closet and re-installed on the wall mounts.

Agree _____ Disagree _____ **X** _____

DHS's Response to IG's Recommendation, as Received:

KEY FINDINGS

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-010, the Interim A/YSA advised that "YSA is in the process of recruiting to fill the position of Health and Safety Officer."

- g. That the A/YSA explore the feasibility of a central locking system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. In response to MAR 03-I-010, the Interim A/YSA advised as follows: "OHYC is a facility that is in need of many capital improvements. We have and continue to investigate the feasibility of installing electronic door releases; however, due to the physical layout of OHYC, this plan has never been feasible. In order to provide additional security measures that will allow faster evacuation of the housing units, YSA will install a lock box in the security office, and the unit manager, supervisory youth correctional officer and the officer of the day will have access to the lock box in the event that an emergency occurs."

- h. That the A/YSA ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.

Agree _____ Disagree _____ **X** _____

DHS's Response to IG's Recommendation, as Received:

In response to MAR 03-I-010, the Interim A/YSA advised that "[i]n order to provide additional security measures that will allow faster evacuation of the housing units, YSA will install a lock box in the security office, and the unit manager, supervisory youth correctional officer and the officer of the day will have access to the lock box in the event that an emergency occurs."

OIG Response: **Actions planned and taken by YSA should adequately address the conditions noted.**

14. Numerous abandoned buildings at OHYC are unsecured and vandalized.

OHYC is located on a large parcel of land in Laurel, MD and is the former location of Forest Haven, a District-run facility for severely handicapped youths. The site contains numerous buildings once used for housing, training, and support that have been unused and

KEY FINDINGS

abandoned since Forest Haven was closed in 1991. The building that served as Forest Haven's laundry still contains commercial-size laundry machines. Several of these vacant buildings have been vandalized and, in some instances, fires have been set.

Although OHYC facilities maintenance employees stated that the buildings were secure, the team was able to gain access to many of them because doors were either open or unlocked. The amount of vandalism and debris observed, such as discarded clothing and other personal items, indicates that unauthorized access to these buildings has been easy and constant.

The team also found that many of these buildings, although not in use, still have active electrical and water service that may have been operational since Forest Haven's closure in 1991 (see photos next page). For example, the team found during its daytime visit to the laundry that the fluorescent lights in the ceiling were turned on.

A Management Alert Report (MAR 03-I-013 at Appendix 14) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 15.

Recommendations:

- a. That the A/YSA ensure that each abandoned building at the OHYC is secured against vandalism and safety risks.

Agree _____ Disagree X

DHS's Response to IG's Recommendation, as Received:

In response to MAR 03-I-013, the Interim A/YSA advised as follows: "While your correspondence generally refers to the OHYC, YSA currently occupies only limited buildings located on the old Forest Haven site. YSA is working with the Office of Property Management ("OPM"), the Office of the Corporation Counsel ("OCC"), and fellow administrations within the Department of Human Services ("DHS") to identify which District of Columbia agency is responsible for securing abandoned buildings on the old Forest Haven site. The preliminary results of our investigation indicate that specific properties discussed in your investigation may belong to DHS's Mental Retardation and Developmental Disability Administration. The DHS Office of the Director will follow up your recommendation."

OIG Response: **That the D/DHS should ensure that all actions planned and taken adequately address the conditions noted.**

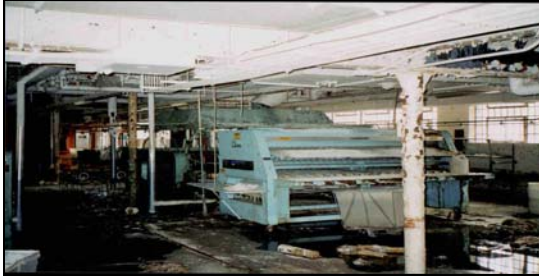
- b. That the A/YSA ensure that utility service to unused buildings is disconnected.

Agree _____ Disagree X

KEY FINDINGS



KEY FINDINGS



KEY FINDINGS

DHS's Response to IG's Recommendation, as Received:

In response to MAR 03-I-013, the Interim A/YSA advised as follows: "YSA has learned that the Forest Haven facility was constructed prior to current water, sewer and electrical standards. YSA cannot disconnect the lights associated with the Forest Haven parcel of land because these electrical systems provide the street lighting necessary to maintain security visibility at the Spruce Cottage (also known as Unit 6 for female residents), along each street in the parcel of the land, for the OHYC Training Academy, and the Union facility. In addition, YSA must maintain water flow because it provides water to all fire hydrants on the property and serves the Woodland Job Corps, which was originally a part of this site."

OIG Response: **Actions planned and taken by YSA should adequately address the conditions noted.**

15. OHYC is not reporting unusual incidents to the DHS Office of Investigations and Compliance as required.

According to DHS, an unusual incident is defined as any significant or extraordinary event that is not routine or that differs from established procedures. Unusual incidents include, but are not limited to, sexual or physical abuse, neglect, serious or suspicious injuries, fraud, and waste²⁴. The DHS Office of Investigations and Compliance (OIC) is responsible for recording and retaining all unusual incident reports; investigating allegations of fraud, waste, and abuse by employees and vendors of DHS; and monitoring and coordinating criminal investigations with area law enforcement agencies.

The team found that although OHYC catalogs all unusual incidents and submits reports to the OHYC Deputy Administrator for Secure Programs for internal review, employees are not forwarding the reports to OIC as required by DHS policy. OHYC recorded 1,399 unusual incidents in calendar year 2002 (the only year documented in retrievable form), but failed to report them to OIC. Employees did not give the team a clear answer as to why reports were not being forwarded. OIC employees and the Deputy Director of DHS stated that they had asked OHYC officials for the reports, but had not received them.

OHYC's failure to properly report unusual incidents as required prevents OIC from tracking and investigating unusual incidents, and prevents DHS from taking any action that might be appropriate.

Recommendation:

That the A/YSA develop a system to ensure that all unusual incidents are promptly reported to DHS OIC.

²⁴ Other examples of unusual incidents include employee and youth behavioral infractions and verbal misconduct, destruction or damage of government property, and "any other incident that would be of interest to the [DHS] Director." (DHS Policies and Procedures for Reporting Unusual Incidents, December 1998.)

KEY FINDINGS

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

16. YSA's fiscal and asset management has many deficiencies.

YSA's Administrative Office is responsible for managing one of the largest budgets in the District. As previously stated, YSA's FY 2003 budget was approximately \$53 million. Approximately \$21 million was expended for salaries and benefits for YSA's employees. The remaining \$32 million was paid to vendors in the following categories to provide services to youths in YSA's care.²⁵

| YSA Funds Paid to Vendors – FY 2003 | |
|--|----------------------|
| Supplies | \$ 1,233,416 |
| Energy, Telephone, Rent | \$ 2,463,382 |
| Security | \$ 526,799 |
| Professional Services | \$ 573,983 |
| Contracts | \$ 8,408,488 |
| Maintenance of Persons ²⁶ | \$ 18,639,141 |
| Equipment Rental and Purchases | \$ 376,002 |
| TOTAL | \$ 32,221,211 |

a. YSA's oversight of contracts has major deficiencies.

The team reviewed a number of contracts from 1998 through 2003 and found numerous deficiencies that may be in violation of District contracting and procurement regulations. The team found that YSA:

- did not have written policies and procedures for accounting and procurement processes;
- did not provide adequate training for procurement employees;
- paid vendors and could not provide documentation of deliverables;
- exceeded funding limits stipulated in contracts;
- did not assign contract administrators;
- allowed vendors to provide services outside the scope of work stipulated in contracts;
- provided advance payments to vendors without proper authorization;
- paid vendors after the expiration of contracts;

²⁵ Youth Services Administration FY 2003 operating budget.

²⁶ This is YSA's terminology for maintenance services that include payments to youth residential facilities, medical and dental services for youth, and mentoring services for youth in the community.

KEY FINDINGS

- paid a vendor twice for the same monthly invoice;
- did not produce statements of work for contracts and used vendors' technical proposals as the foundation for service agreements; and
- was unable to locate copies of several requested contracts.

The review of contracts also found that the Office of Contracting and Procurement (OCP) issued a contract as a sole source agreement without a proper "determination and finding" document to justify the sole source procurement, and did not include reporting and quality requirements in some contracts

b. YSA was suspended from the D.C. Purchase Card program for policy violations.

The D.C. Purchase Card Program (Program) was initiated due to the District's need for a mechanism to deal more effectively with micropurchases.²⁷ The purpose of the program is to enable agencies to quickly purchase needed goods and services and increase efficiency of District programs by reducing paperwork and administrative costs for high volume, small dollar value purchases. OCP and the Office of the Chief Financial Officer (OCFO) distribute purchase cards throughout the District government. 27 DCMR *Contracts and Procurement* permits the use of Purchase Cards.

According to OCP policies and procedures, individuals issued a purchase card must use the purchase card only for official government business directly related to the programmatic function of the cardholder's programs within the agency or administration.

Each agency is responsible for ensuring proper management and oversight of purchase card activities and must prevent waste, fraud, abuse, and mismanagement by:

- developing purchase card acquisition budgets;
- designating agency program participants in the Purchase Card Program;
- assuring that all agency participants attend and complete training;
- ensuring compliance with procurement rules and regulations; and
- prohibiting unauthorized use of purchase cards by cardholders.

The AD is also responsible for providing information and/or reports concerning the use of purchase cards within the agency and on behalf of the agency. The team requested a report listing all cardholders and purchase card transactions for FY 2001 through FY 2003 and found that:

- YSA did not generate proper reports regarding the Program;
- purchase card reports did not reconcile with reports obtained from OCP and the monthly statements supplied by the bank issuing the purchase cards;
- cardholders split purchases in violation of policies and procedures;²⁸ and

²⁷ Small purchases valued at \$2,500 or less.

²⁸ Splitting purchases is an unauthorized practice prohibited by D.C. Code § 2-303.21 that is characterized as intentionally breaking down a known buying requirement in order to stay under the small purchase dollar

- The team found that OCP repeatedly cited YSA for violating program policies and procedures and ultimately suspended several cardholder accounts in 2002.

YSA manages a large warehouse operation at OHYC. The warehouse receives and distributes supplies to various YSA facilities including:

- Through physical observations and a review of YSA inventory reports, the team found that many of the items in the warehouse were not included on the reports. In addition, YSA does not maintain an inventory tracking system and does not conduct an annual inventory of the supplies in the warehouse. The warehouse manager stated that items often arrive at the warehouse without purchase orders or receipts, and employees remove items as needed. She also stated that she was not trained in warehouse operations.

Recommendations:

- Agree **X** Disagree

limitations. OCP policies and procedures state that purchase cards shall only be used to buy commercially available goods and services with a value that does not exceed \$2,500 per single transaction.

Youth Services Administration – March 2004
62

KEY FINDINGS

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The Interim A/YSA will request a review and audit of all YSA contracts for FYs 2003 and 2004 once YSA's Deputy Administrator for Support Services (Chief Administrative Officer) has been hired. YSA already has begun the process of reviewing contracts with the Agency Chief Contracting Officer.

- b. That the A/YSA request that OCP and OCFO conduct an audit of the D.C. Purchase Card Program at YSA.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The Interim A/YSA will request that OCP and OCFO audit the D.C. Purchase Card program once YSA's Deputy Administrator for Support Services (Chief Administrative Officer) has been hired. YSA has only one active purchase card for the agency.

- c. That the A/YSA develop and enforce policies and procedures to ensure control and accountability of warehouse operations, and ensure that a qualified employee is in charge.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

17. Deficiencies within YSA's Information Technology (IT) infrastructure may impair its ability to effectively manage day-to-day operations.

Many of YSA's basic operations are dependent upon the Juvenile Information Management System (JIMS). JIMS is a computer database that stores confidential and time-sensitive legal, family, and treatment information for each youth currently under the supervision of YSA. YSA employees at OHYC, the Bureau of Court and Community Services (BCCS), and the Court Liaison unit (located at D.C. Superior Court) use JIMS to track youths within the District's juvenile justice system, facilitate communication, coordinate the efforts of various service providers, and record the results of various diagnostic and treatment services. Examples of vital information stored in JIMS include:

- daily status and location information for each youth at OHYC;
- legal offense histories for all youths committed to YSA;
- intake forms that detail social and family histories;
- case assignments to YSA personnel;

KEY FINDINGS

- case running notes, which capture information about case-related correspondence, service requests, and each youth's progress toward treatment goals;
- court appearance reports;
- counseling and treatment session notes;
- placement and transfer decisions; and
- discharge decisions and authorizations.

a. YSA's IT staff currently does not have the level of familiarity necessary to maintain and troubleshoot JIMS operability on a daily basis.

Although YSA has two employees assigned to IT matters, it also contracted with an outside consultant to manage JIMS.³⁰ This consultant is responsible for JIMS user account and database maintenance, technical support, and system performance enhancement, and provides network administration, email system management, and "help desk" support. Based on the team's interviews and observations, YSA's IT consultant appears to have been performing as the de facto IT Chief for YSA.

The consultant and YSA's IT Chief both stated that they do not know who will be responsible for maintaining JIMS and other critical IT functions following the expiration of the consultant's contract in February 2004. The IT Chief stated that YSA has neither the consultant's personnel nor the technical expertise needed to assume oversight of JIMS and other specific tasks currently performed by the consultant.

The consultant stated that he has participated in several meetings attended by various D.C. government IT personnel to discuss who will provide the services he now delivers. He stated that no additional meetings have been scheduled. He further stated that if arrangements have been made to transfer oversight of JIMS to D.C. government employees or to another contractor, he has not been asked to participate in the transition process. He emphasized that a proper transfer of JIMS responsibilities, as well as other operations he currently manages, would require a thorough review process and adequate documentation of the system. The consultant voiced concerns about YSA's ability to maintain JIMS if his contract is not renewed.

JIMS is a mission-critical computer application and YSA relies heavily upon the consultant's knowledge and experience with the system. If the consultant's contract is not extended, the functionality and reliability of JIMS may be in jeopardy unless other knowledgeable IT service providers are in place.

The team found that YSA's IT staff currently does not have the level of familiarity necessary to maintain and operate JIMS on a daily basis. Without this type of expertise, YSA case managers may experience interruptions in JIMS access and difficulties in reviewing vital case information. If YSA were to experience a catastrophic failure of JIMS after the contract expires, it is unclear to the team how YSA would manage the situation, restore JIMS functionality, and preserve the integrity of YSA's data.

³⁰ This consultant has provided services since October 1, 2002.

KEY FINDINGS

b. JIMS cannot generate basic statistical reports.

YSA must routinely provide the court monitors, the District's Corporation Counsel, and other parties with aggregated information about occupancy levels at OHYC, compliance data, staffing levels, and statistical information regarding services provided to each youth.

The team found that JIMS is unable to generate basic statistical reports. YSA employees responsible for compliance monitoring and policy development must manually review case files in order to collect routine information. In order to view information such as the average length of stay for detained youths, or the names of committed youths admitted to OHYC during a specific time period, YSA staff members must review individual hard copy case files, activity logs, and other documents.

The team reviewed contracts and technical specifications pertaining to the development and implementation of JIMS. The IT contractor that developed JIMS did not incorporate into YSA's software package various reporting capabilities that were referenced in the technical specifications of the contract. A review of subsequent contracts with IT service providers indicates that YSA has not been able to improve the reporting capability of JIMS.

The inability of the JIMS system to generate statistical reports impedes the tracking of routine services. YSA's inability to quickly access routine information also impacts its participation in a nationwide Performance Based Standards Project (PBS).³¹ Additionally, the lack of adequate reporting data impedes accountability within the case management system by not giving supervisors the ability to easily monitor the thoroughness and efficiency of case managers and adherence to treatment service deadlines.

c. Underutilization of JIMS creates administrative burdens for OHYC's Social Services employees.

The YSA Case Management Manual at page 52 states that "[e]ach [OHYC] discipline providing services to the youth will complete Monthly Treatment Reports in JIM[S]."

The team found that not all departments providing services at OHYC use JIMS as required. The medical unit, mental health unit, and the Oak Hill Academy do not enter information in JIMS.³² Several OHYC departments do not have basic computer access. For example, the employee responsible for coordinating recreation screenings did not have a computer, a user account on JIMS, or an email account. Furthermore, the team found that many employees had not received formal training on the system.

³¹ The PBS Project is an effort by the Council of Juvenile Correctional Administrators to collect information from over 100 detention and correction centers. Participation in this program is designed to develop a set of standards that individual facilities should strive to meet; create tools to help facilities achieve these standards through regular self-assessment and self-improvement; allow facilities to evaluate their performance over time and in comparison to similar facilities; and promote effective practices and help facilities support each other. As a participant, YSA must collect of a wide range of administrative and case-specific data. See www.cjca.net.

³² Oak Hill Academy is the educational unit at OHYC operated by the District of Columbia Public Schools.

KEY FINDINGS

Social Services employees at OHYC, in particular the treatment team leaders, are ultimately responsible for coordinating and ensuring the provision of all services and treatment for each youth. Due to the underutilization of JIMS, the treatment team leaders and other Social Services employees must spend a considerable amount of time each month collecting information from other departments and entering it into JIMS. This adds to their administrative burden and, more significantly, prevents the treatment team leaders from devoting more time to youths and programming.

The absence of information in JIMS also impedes communication between the various departments and creates inefficiency. For example, in order for a treatment team leader to check the status of a specific youth, he or she must telephone or visit each department to review its hard copy case file.

Recommendations:

- a. That the A/YSA expedite meetings of representatives from DHS's Office of Information Systems, the District's Office of the Chief Technology Officer (OCTO), and YSA, to discuss engaging OCTO technical expertise until YSA employees can be sufficiently trained on JIMS.

Agree **X** Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. YSA had contracted for JIMS technical expertise through January 2004. Beginning in December 2003, the A/YSA began working with DHS's OIS and OCTO to discuss YSA's IT deficiencies and future needs. In February 2004, OCTO took over day-to-day operations of YSA's network and worked with YSA and OCP to develop an RFP for a new contractor to support JIMS while a replacement system is developed and implemented in conjunction with DHS, YSA and OCTO.

- b. That A/YSA give priority to ensuring that JIMS is made capable of producing all reports necessary for supporting OHYC supervision and tracking of detained and committed youths, as well as statistical information required by the court and other entities with a vested or otherwise appropriate interest in YSA operations.

Agree _____ Disagree **X** _____

DHS's Response to IG's Recommendation, as Received:

YSA contracted for JIMS technical expertise through January 2004, including programming for reports. Beginning in December 2003, the A/YSA began working with DHS's OIS and OCTO to discuss YSA's IT deficiencies and future needs. Because it is based on Lotus Notes rather than more mainstream applications such as Oracle or SQL, one of JIMS's deficiencies is its lack of a broad support network. In February 2004, OCTO took over day-to-

KEY FINDINGS

day operations of YSA's network and worked with YSA and OCP to develop an RFP for a new contractor to support JIMS while a replacement system is developed and implemented in conjunction with DHS, YSA and OCTO. In addition, DHS has entered into an MOU with OCTO for work with the Superior Court and other human service agencies on interface issues.

OIG Response: **Actions planned and taken by YSA should adequately address the conditions noted.**

- c. That the A/YSA provide all departments at OHYC with reliable, secure access to JIMS.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. Consistent with ongoing discussions with DHS's OIS and OCTO, the A/YSA will "provide all departments at OHYC with reliable, secure access to JIMS" pending development and implementation of a replacement system.

- d. That the A/YSA ensure that all JIMS users receive appropriate training and ongoing IT support.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. Consistent with ongoing discussions with DHS's OIS and OCTO, the A/YSA will "ensure that all JIMS users receive appropriate training and ongoing IT support" pending development and implementation of a replacement system.

Findings and Recommendations: SECURITY

18. YSA does not have policies, procedures, or staff to handle an escape from OHYC.

The possibility of escapes from OHYC is a constant threat to the safety of the surrounding community. Every effort should be made to minimize and/or eliminate these occurrences. According to Administrative Issuance # YSA-I.1-011, YSA has the responsibility and authority to request a custody order when a youth escapes from the grounds at OHYC.

The ACA recommends written procedures that are reviewed at least annually and updated as necessary. ACA further recommends that specific procedures be made available to all personnel that can be referenced quickly when an escape occurs. These procedures should include:

- prompt reporting of the escape to the facility administrator;
- mobilization of employees;
- implementation of a predetermined search plan;
- notification of law enforcement agencies, community groups, and relevant media;
- preparation of escape circulars for distribution and mailing; and
- prompt notification to all who were previously alerted, after apprehension of the escapee.

The team found that although there were written procedures in place for the escape notification process and custody order requests,³³ there are no written procedures that detail a step-by-step process for the procedures recommended by ACA or other specific procedures that should be followed quickly in the event of an escape. In addition, the team found that YSA does not have adequately trained staff at OHYC to be mobilized in the event of an escape.

The OHYC Assistant Superintendent for Security and the Chief Operating Officer for YSA maintain the primary responsibility for responding to escapes and have acquired knowledge concerning response procedures through on-the-job training, without the assistance of written procedures. The responsibility of drafting appropriate written procedures has never been delegated.

Time is one of the most critical elements involved in the apprehension of escapees. The lack of specific written procedures and adequate staff may decrease OHYC's ability to act promptly and ensure that every measure of the apprehension process is completed.

Recommendations:

- a. That the A/YSA ensure that thorough and complete escape response procedures are drafted, implemented, and distributed to all key personnel.

Agree X Disagree _____

³³ Notification to the Court that a youth has escaped.

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA ensure that adequately trained staff are available at OHYC to be mobilized in the event of an escape.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

19. YCOs have not had emergency response training.

ACA recommends that security employees be provided training on how to handle a riot or uprising among the residents. This training should include the distribution of a written Hazard Continuity and Contingency Plan for Emergencies. The plan should carefully instruct staff on how to handle emergencies and designate a chain of command in the event of emergencies.

OHYC has an extensive written Hazard Continuity and Contingency Plan for Emergencies, but it has only been distributed to supervisors. YCOs stated they are unaware of a contingency plan and are not aware of the chain of command in the event of a riot or uprising among the residents.

YSA does not require YCOs to undergo formal emergency response training, and the team found that YCOs do not have such training. According to a supervisory YCO, he takes small groups of YCOs to the open field by the Oak Hill Academy and teaches them various riot handling techniques when he has the time. If a serious disturbance were to take place, however, YSA could not ensure that this sporadic and informal training would be adequate.

Recommendations:

- a. That the A/YSA ensure that all YCOs receive a copy of the Hazard Continuity and Contingency Plan.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA ensure that YCOs receive emergency response training.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

20. Youths are not photographed when remanded to YSA's custody.

YSA's Case Management Operations Manual provides at page 12 that "[i]mmediately after a youth is ordered into YSA care and/or custody, a YSA Court Liaison Screener will meet with the youth to complete a basic screening...The Screener will also take a photograph of the youth for YSA's case file." The Manual further states, at page 16, that "[t]he OHYC Intake Staff will...take the youth's photograph if it was not taken by the Court Liaison Unit."

The team found that although it is the YSA Court Liaison Screener's responsibility to photograph youth upon arrival, youth are not being photographed. The team reviewed the files of numerous youths and found that none had photographs. The YSA Superintendent for Secure Operations stated that photographing each youth is too costly for YSA to do at this time. He further stated that although there is a machine capable of making photographic identification cards at OHYC, it is broken.

YSA employees are unable to accurately identify youths at OHYC without photographs, and if a youth escapes, employees do not have photographs that will aid law enforcement officials charged with finding the escapee.

Recommendation:

That the A/YSA ensure that each youth is photographed upon arrival at OHYC, and that a copy of this photograph be filed as required.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

21. The number and location of physical restraints are not accounted for and OHYC officials are not effectively monitoring their use.

The ACA standard regarding the use of restraints states: "Instruments of restraint should only be used as a precaution against escape during transfer; for medical reasons by

direction of the medical officer; or to prevent juvenile self-injury, injury to others, or property damage; and should not be applied for more time than is absolutely necessary.”³⁴

YSA’s use of physical restraints policy states:

The Superintendent will identify a secure area for the storage of all security equipment within the facility/institution. In case of emergencies, restraints shall also be stored in the Control Center. Serial Numbers for each piece will be recorded, and a monthly inventory will be reported to the Superintendent and/or designee by the Control Clerk. A record (Log Book) will be kept to document the issuance and use of all restraining equipment.³⁵

The team found that accountability for the use and storage of physical restraints (restraints) at OHYC is lacking. YSA was unable to provide an inventory or identify a centralized location where all restraints are located. In addition, YCOs are not signing out restraints.

Because YSA officials do not keep an accurate count of the restraints at OHYC, they cannot verify that only authorized personnel have access. In addition, without proper inventory and log-out procedures, they cannot ensure that restraints are used appropriately and with authorization. Although YSA does maintain a logbook that documents when restraints are used for any purpose other than transportation, the usefulness of the logbook is limited by the fact that there are no controls enforced regarding their use and distribution.

Recommendation:

That the A/YSA follow established policies and procedures regarding the inventory and use of physical restraints.

Agree X Disagree _____

DHS’s Response to IG’s Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG’s factual findings.

22. Some OHYC electronic monitoring systems are inoperative.

OHYC uses electronic monitoring systems (electronic security system cameras and viewing screens) to provide real-time viewing of both the interior and exterior of housing units

³⁴ ACA Standard 3-JTS-3A-16.

³⁵ YSA Policy Number YSA 9.6.

and outer perimeter areas. These systems are located within the housing units and the gatehouse control booth. YCOs are responsible for monitoring all electronic security and surveillance equipment.

The team found several monitoring systems at OHYC inoperative, including systems in the gatehouse and the male and female housing units. According to YCOs, some of the electronic security systems have been inoperative for several years.

Recommendation:

Agree **X** Disagree

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. DHS has requested that DOC provide a security assessment of OHYC. Consistent with that security assessment and to the extent practical, the A/YSA will repair and maintain all electronic monitoring systems at OHYC.

The gatehouse serves as the entrance and exit into the OHYC secured facility. No one is allowed to enter the facility unless searched by security guards, and identification must be presented.

The team noted during work observations that the top door hinge leading to the control booth area was missing and the door was ajar. YCOs stated that often the door remains open and unlocked, regardless of the missing hinge, in order to admit transportation officers into the

Youth Services Administration – March 2004

SECURITY

control booth area to store and retrieve restraints used for youths being transported outside of OHYC. YCOs stated that several verbal requests had been made to the Assistant Superintendent of Security Operations to have the door repaired; however, he has been unresponsive.

Prior to entering or exiting the facility, visitors are momentarily detained adjacent to the control booth. Because the door to the gatehouse control booth cannot be secured, unauthorized persons may gain entry to this area, operate the control panel, and assist youths in escaping.

Recommendations:

- a. That the A/YSA ensure that the hinges on the gatehouse control booth door are repaired.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA develop policies and procedures to ensure that the gatehouse control booth door remains locked and secured at all times.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- c. That the A/YSA discontinue the storage of physical restraints in the gatehouse control booth area.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

24. Policy and procedures manuals are not available in 9 of 11 youth housing units.

ACA has established manuals of standard operating procedures to assist employees in successfully completing assignments and to ensure compliance with facility policy and procedures.

The ACA standard regarding policy and procedure manuals states: “The policies and procedures for operating and maintaining the facility and its satellites are specified in a manual that is accessible to all employees and the public. This manual is reviewed at least annually and updated as needed.”³⁷ ACA further recommends: “Each department and major administrative unit in the institution maintains and makes available to employees a manual of standard operating procedures that specifies how policies are to be implemented. These procedures are reviewed at least annually and are updated as needed.”³⁸

YSA has written policies and procedures; however, the team found that only 2 of the 11 housing units had them on site. The YCOs stated that many procedures and directives are oral, and the current written policies in these two housing units are outdated and are not applicable to current daily operations.

The team also noted that the Assistant Superintendent for Security Operations did not have readily accessible written policies and procedures. The team requested copies of several policies but was referred to other sources within the OHYC.

Failure to distribute written policies and procedures to the housing units contributes to inconsistency in daily operations and may jeopardize the safety and security of youths and YCOs.

Recommendations:

- a. That the A/YSA develop up-to-date policies and procedures that govern daily housing unit operations.

Agree X Disagree

DHS’s Response to IG’s Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG’s factual findings.

- b. That the A/YSA ensure dissemination of an updated policy and procedures manual to all housing units and to all personnel as appropriate.

Agree X Disagree

³⁷ ACA Standard 3-JTS-1A-17 (Ref. 2-9015).

³⁸ ACA Standard 3-JTS-1A-18 (Ref. New).

**Findings and
Recommendations:
YOUTH SERVICES**

25. Project Hands does not complete investigative reports within the 10-day requirement.

Project Hands resulted from a provision of the Decree that ordered the District of Columbia to investigate and provide written reports of all allegations against staff for violating regulations applicable to youths. Project Hands is DHS's internal and independent office responsible for investigating and reporting all allegations of child mistreatment that occur in the District's juvenile justice institutions and facilities. Although physically located at OHYC, Project Hands personnel report directly to the Director of DHS.

If youths believe their rights have been violated, they are to notify the Project Hands office by placing a written complaint in one of the clearly identified, locked complaint boxes located throughout the residential units, the mental health unit, and the Oak Hill Academy. In addition, a youth may have someone else, (e.g., the attorney of record, parent/guardian, case manager, the Public Defender Service, other staff member, or an anonymous party) contact the Project Hands office directly to refer their complaint.

According to DHS policies and procedures, a Project Hands investigator is required to contact the youth within 24 hours of receiving the complaint, and deliver an investigative report within 10 days of the incident report to the OHYC Superintendent, the Decree Monitor, plaintiffs' counsel, the DHS Office of the General Counsel, the Office of the Corporation Counsel, and the Commissioner for Social Services.

The team reviewed the Project Hands complaint case log for the period of January 1 through June 30 of 2003, and found that the investigative reports for 21 of the 26 cases listed (81%) were not issued within the 10-day requirement. Many reports were issued weeks or months later, which is in direct violation of the Decree and agency policy.

Project Hands management stated that due to their inability to obtain information from YSA personnel and the time consuming nature of the investigation process, they have been unable to complete the investigative reports within 10 days. The consistent failure to deliver investigative reports within 10 days prolongs the period of time necessary for proper disciplinary action to be taken and is a violation of the Decree. In addition, it may expose the District and YSA to financial penalties for non-compliance.

Recommendation:

That the Director of DHS take necessary actions to ensure that the 10-day investigative report requirement is met.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

YOUTH SERVICES

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. YSA is recruiting an additional investigator for Project Hands and has otherwise met the Jerry M. Consent Decree staffing requirements.

26. YSA's drug screening program has serious deficiencies.

The YSA Case Management Operations Manual requires at page 17 that approximately 50 percent of all youths in custody be randomly drug tested each week. YSA is also required to conduct drug testing of a specific youth if directed by a court order. This testing would occur at intervals dictated by the order.

YCOs are responsible for the collection of urine samples used for drug testing. These samples are then sent to an outside contractor for testing. The results are returned to YSA, and the YCOs are responsible for entering test results into the JIMS. YSA case managers review this information and develop drug treatment and service plans. To ensure the development of effective drug treatment and service plans, an effective drug testing program is essential. The team reviewed the drug screening process and found many deficiencies.

a. YSA lacks written policies, procedures, and training for the collection of urine specimens.

ACA standards require that each department and major administrative unit in the institution maintain a manual of standard operating procedures that specify how policies are to be implemented. In addition, the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) suggests that all collectors of urine specimens be trained.³⁹

YSA does not have written policies and procedures for the collection of specimens. Additionally, the team found that YCOs collecting specimens have not been provided training in the national standards for the collection of urine samples.

YCOs collecting specimens are relying on verbal instructions handed down by former employees and could not provide the team with a detailed, step-by-step process that is used consistently by all YCOs. Training in the collection of urine specimens is not included in pre-service training provided to YCOs, even though this is a required component of their job responsibilities.

The lack of written policies and procedures and training has resulted in an unstructured, unreliable collection process. The team reviewed records provided by the contract drug testing company and found that some specimens were not tested because YSA did not use proper bottles for urine specimen collection, bottles were empty when received, samples were adulterated with either soap or bleach, or YCOs had failed to record the temperature immediately after the sample was taken.

³⁹ SAMHSA sets the national standards for the collection of urine specimens for the purpose of drug testing.

- b. YSA has not established a chain of custody for the urine specimen collection process and is not properly securing samples prior to delivery to the drug testing contractor.***

Collected urine samples pass through the custody of several people at OHYC before being delivered to the lab for testing. Best practices recommend that all urine specimens be collected using a chain of custody form and that all samples be properly secured prior to testing. The chain of custody is the process of documenting the handling and storage of a specimen, from the time a donor gives the sample to the collector until the drug test is complete and the urine has been discarded, to ensure that samples do not become contaminated.

Currently, YCOs do not document any portion of the urine collection and storage process. The team found that YSA does not have a chain of custody form to accompany the urine sample throughout the specimen collection process.

The team also found that although the urine samples are stored in a locked closet in a locked refrigerator, the keys to these locks are not controlled; therefore, all staff have access to the keys, and consequently access to the urine specimens.

Because YSA lacks adequate chain of custody and storage procedures, it cannot ensure that urine samples have not been tampered with and cannot hold individuals accountable for contaminated or defective urine samples.

- c. Accurate records are not kept of urine samples or drug test results.***

According to YSA policies and procedures, employees must retain a copy of the test forms that accompany the urine samples. These test forms are kept to ensure that YSA is conducting an adequate number of random drug tests.

Additionally, YSA should maintain records of all drug test results to ensure that they are properly entered into JIMS and can be readily provided to the court if court ordered testing is mandated.

The team requested all available records for urine samples and drug testing results. YSA could not provide a comprehensive file containing all drug testing sample records or results. YSA gave the team records that dated from January 2003 until early June 2003. The team also found unfiled records located throughout different offices within the facility.

Due to the lack of an effective drug testing policy, YSA cannot ensure that either random or court-ordered drug testing is being conducted properly and produces accurate results.

Recommendations:

YOUTH SERVICES

- a. That the A/YSA establish written policies and procedures for drug testing and a training program for collectors of urine specimens.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA establish a chain of custody for the urine collection process.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- c. That the A/YSA ensure that accurate records are kept of the drug screening process.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

27. YSA staff members are constrained by unrealistic diagnostic and reporting deadlines.

Upon arrival at OYHC, each youth undergoes a series of comprehensive diagnostic assessments during which YSA staff members collect information on educational and vocational background, mental health, medical condition, and social history. Diagnostic and treatment personnel at OHYC use this information to evaluate the youth's strengths and needs, and to develop an Individual Service Plan (ISP) that lays out the programs and services to be provided to assist in the youth's rehabilitation. The Decree mandates development of an ISP by the end of the second week after admission. This is followed by monthly meetings to review and report on a youth's progress in achieving the ISP goals and to make any modifications to the ISP.

The team found that the 2 weeks mandated for development of an ISP is insufficient to allow YSA diagnostic personnel to create an accurate initial assessment of a youth's strengths and needs. Treatment team leaders (TTLs) stated that many youths enter OHYC with drugs in their systems and are under the influence of one or more drugs during much of the diagnostic period. Those under the influence of marijuana, cocaine, and PCP require at least 14 days of detoxification. TTLs also stated that until a youth's system is free of drugs, the diagnostic staff

YOUTH SERVICES

cannot begin to accurately assess his/her personality, determine treatment needs, and develop an effective ISP.

In addition, as part of the 14-day diagnostic phase, BCCS case managers are required to obtain a family history as well as information about the youth's friends, neighborhood peer group, and home environment. Case managers stated that the 14-day ISP deadline often does not give them enough time to interview family members, neighbors, and other people who can provide insight into the youth's history. As a result, the diagnostic and treatment teams do not have this important information when developing the ISP during the initial treatment team meeting. The Decree requirement that YSA treatment teams review and update each youth's ISP every 30 days is also seen as burdensome.

The team found that the timeframes for development and review of services plans are more generous in Maryland and Virginia. For example, in facilities managed by Maryland's Department of Juvenile Justice, a case manager has 25 days to complete a Treatment Service Plan (the equivalent of OHYC's ISP). Following the implementation of the service plan, a case manager in Maryland must review and update each service plan at minimum intervals of 90 days as noted above and as otherwise necessary to reflect any changes in a youth's status.

The standard timeframe for completing the diagnostic process in Virginia is similar to Maryland's. The team reviewed Virginia's standards for the development of service plans within secure juvenile facilities and found that an individual service plan must be developed within 30 days following admission. Subsequently, each plan should be updated quarterly, or more frequently "if necessary."

YSA case managers stated that the current assessment and review requirements prevent them from spending more time with the youths on their unit, requiring them to be "paper processors" rather than clinicians.

Recommendation:

That the A/YSA discuss with the Office of the Corporation Counsel the feasibility of a meeting with the Court-appointed monitors and the Decree plaintiffs' attorneys to negotiate an extension of the diagnostic timeframe and reporting requirements in order to ease the administrative burden created by the current treatment plan deadlines.

Agree **X** Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. YSA works directly with the Office of the Corporation Counsel with respect to compliance with the Jerry M. Consent Decree. YSA understands and agrees with the OIG's recommendation but is unable to respond more fully given privilege and confidentiality concerns in the litigation context.

28. Administrative support for OHYC treatment team leaders is insufficient.

The team found that for the past several years, TTLs have not been provided adequate administrative support. TTLs stated that in addition to a TTL, OHYC used to staff each housing unit with a Social Services Representative (SSR). The SSR was responsible for the administrative tasks of the unit such as placing and answering telephone calls, recording data related to treatment team meetings, documenting youths' ISP updates, and maintaining case files. The team found that only 3 of 11 housing units currently have a SSR to assist with administrative tasks.

Without adequate administrative support, TTLs spend a disproportionate amount of time on administrative tasks (such as processing paperwork) rather than providing individual and group therapy or working on therapeutic programming for the youths in their unit.

That the A/YSA expedite the hiring of additional personnel to adequately support the treatment team leaders.

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. YSA is in the process of hiring additional treatment team leaders and is working closely with the OHYC Assistant Superintendent for Treatment to identify "additional personnel to adequately support the treatment team leaders" at OHYC and YSC consistent with FY 2005 budget constraints.

Youth Services Administration – March 2004

YOUTH SERVICES

Numerous D.C. government agencies provide services at OHYC. For example, employees of the Department of Mental Health (DMH) provide initial screenings and ongoing mental health treatment. The supervisory medical officer coordinates a team of Department of Health (DOH) and YSA employees and contracted staff to provide medical care. District of Columbia Public Schools (DCPS) employees conduct education screenings and provide daily instruction, and YSA Social Services department employees lead weekly individual and group therapy sessions and develop other types of rehabilitative programming. TTLs at OHYC must coordinate the efforts of these various major departments to ensure youths receive the diagnostic and treatment services stipulated in their ISPs.

In order to provide efficient, comprehensive treatment, the various service providers at OHYC must communicate effectively. ACA standards recommend maintaining channels of communication by holding at least monthly meetings “between the facility administrator and all department heads and their key staff members.”⁴⁰

The team found that OHYC does not hold regular meetings attended by representatives from each of the major departments. Employees stated that the former OHYC Superintendent used to convene a monthly meeting of all major department heads, but those meetings were discontinued when he departed in June 2003, and they have not resumed.

Employees stated that due to the lack of monthly meetings, they are often unaware of new initiatives in other departments and cannot inform youths about new procedures or programs. They further stated that this lack of communication creates a costly administrative burden for the TTLs. Because TTLs must coordinate and ensure the delivery of services by various departments, poor communication requires them to expend significant time and effort tracking referrals and information; reduces the amount of time available for therapeutic activity; and leads to a breakdown in the execution of the elements of a youth’s ISP.

Recommendation:

That the A/YSA reinstate the practice of convening a meeting of all OHYC department heads on, at minimum, a monthly basis.

Agree X Disagree _____

DHS’s Response to IG’s Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG’s factual findings. Since her arrival in December 2003, the Interim A/YSA has conducted several such meetings.

30. Parent participation in diagnostic and treatment team meetings is extremely low.

A youth’s parents or guardians are expected to participate in a number of key meetings with OHYC diagnostic and treatment personnel. Upon completion of the diagnostic assessments

⁴⁰ ACA Standard 3-JTS-1A-21 (Ref.2-9016).

and by the 15th day after each youth's admission, a diagnostic staff meeting is held. At that meeting, personnel who completed the assessments, along with other members of the OHYC treatment staff, meet to develop an ISP for the youth. The youth is present at this meeting and the youth's parents or guardians are invited to attend. In addition, once the ISP has been developed, members of the youth's treatment team meet every 30 days to discuss the youth's activities and progress toward the goals enumerated in his or her ISP. The youth attends these monthly meetings, parents are invited, and all OHYC personnel who provide services to the youth are expected to attend.

TTLs stated that the majority of parents do not participate in diagnostic and treatment team meetings due to time and location constraints. Despite the fact that social services staff members make a concerted effort to contact youths' families both by mail and by telephone, one TTL stated that of the 20 youths on her unit, only 2 sets of parents participate in monthly treatment team meetings.

Parents and guardians should be key participants in the rehabilitative process and, when they do not attend treatment team meetings, they miss an opportunity to interact not only with their child but also with those OHYC staff members who provide services to their child.

- a. That the A/YSA procure telephone equipment and service in the room where the weekly treatment team meetings are held so that parents will be able to participate in these meetings via teleconference.

DHS's Response to IG's Recommendation, as Received:

Youth Services Administration – March 2004

YOUTH SERVICES

- b. That the A/YSA lead an initiative, staffed by members from all of OHYC's major departments, to identify additional ways to improve parent participation in the treatment team process.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. While the Interim A/YSA agrees with the need "to identify additional ways to improve parent participation in the treatment team process," this initiative should be led by the respective Assistant Superintendents for Treatment.

31. OHYC home visitation policies are not uniformly applied.

Home visitation is a privilege that is awarded to OHYC youths who have attained certain treatment goals and maintained established behavioral standards. These home visits range from a single day to a full weekend stay. According to YSA policies and procedures, OHYC's TTLs and the youth's Bureau of Court and Community Services (BCCS) case manager share case management responsibilities for each youth at OHYC and are to collaborate on the decision to grant home visits.

YSA policy states that:

In order for a youth to be eligible for visits he/she must not have been involved in a major rule violation for at least thirty (30) days, must **not** be serving a restriction, and must have progressed to the appropriate STRIDE⁴¹ Programmatic Phase (Purple Phase). Exceptions to the criteria may be made in the event of family emergencies or other documented legitimate reasons, as determined and concurred upon by the youth's Treatment Team, aftercare case manager, and court if applicable.⁴²

The team found that home visitation privileges are not uniformly granted. Some youths who had met all the necessary criteria were denied a home visit. Similarly, BCCS case managers have requested day passes for youths who have not reached the requisite stage in the STRIDE program. The team found that the final decision to allow home visitation is ultimately made by BCCS case managers who are often reluctant to grant an eligible home visit out of concern that a youth might escape while on visitation.

⁴¹ STRIDE is a behavioral program at Oak Hill in which a youth can earn additional responsibilities and privileges through good behavior. As the youth moves through the four different phases, he gains more control over his environment. The Purple Phase of STRIDE is the highest level of achievement in the program.

⁴² Policy # YSA 19.3, dated August 7, 2003.

YOUTH SERVICES

OHYC treatment team leaders stated that failure to apply home visitation policies uniformly is dissuading many of the affected youth from working toward their treatment goals and striving for good behavior at OHYC.

Recommendation:

That the A/YSA ensure that the home visitation policy is reviewed and is more uniformly applied.

Agree **X** Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. While the Interim A/YSA agrees with the need to "ensure that the home visitation policy is reviewed and is more uniformly applied," there are other issues that often dictate whether home visitation is permitted or advisable in the circumstances.

32. OHYC does not have a dietician to ensure compliance with nationally recommended daily food allowances.

The ACA recommends that a dietician annually review a facility's dietary allowances to ensure compliance with nationally recommended food allowances.⁴³ ACA further recommends that dieticians use the recommended dietary allowances developed by the National Academy of Sciences as a guide for basic nutritional needs.

According to the OHYC food service manager, OHYC does not have a dietician. He stated that a review of the meals prepared and served at OHYC has not been conducted during his 3-year tenure. He further stated that the Master Menu used to prepare meals at OHYC is a menu that was used by St. Elizabeth Hospital's Food Service Division, and was approved by a dietician in 1999. It has not been updated to reflect changes in recommended dietary allowances.

Several employees stated that without proper nutritional meal planning by a qualified dietician, meals served to youth may not be nutritionally balanced.

Recommendation:

That the A/YSA hire a full-time dietician or a dietary consultant to review menus and ensure compliance with federally recommended daily food allowances.

Agree **X** Disagree _____

⁴³ According to the National Academies Press, nationally recommended food allowances are the levels of intake of essential nutrients that, on the basis of scientific knowledge, are judged by the Food and Nutrition Board to be adequate to meet the known nutrient needs of practically all healthy persons.

YOUTH SERVICES

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

33. OHYC does not have written policies and procedures for youths who require special diets due to religious dietary standards.

The ACA recommends written policies and procedures that provide special diets for youths whose religious beliefs require adherence to religious dietary standards. The diets should be approved by the OHYC chaplain, provided to the food service manager in writing, reviewed on a monthly basis, and should be complete and specific. ACA further recommends that these special diets be kept as simple as possible and should conform as closely as possible to the foods served to other youths.

According to both the chaplain and food service manager, OHYC lacks a written policy for special diets based upon religious beliefs or dietary standards. The chaplain stated that he is unaware of any youths at OHYC who require special diets based upon their religious beliefs. He also stated that if youths express an interest in having special diets, every effort will be made to accommodate them.

The absence of a written policy might delay the implementation of special diets for youths who request such diets. Furthermore, the lack of written policies and procedures leaves interpretation of various religious dietary laws to the sole discretion of the chaplain and does not ensure uniform application to all youths at OHYC.

Recommendation:

That the A/YSA seek either internal or external expertise in developing written policies and procedures for dietary plans for youths with religious beliefs that require special diets.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

34. The number of special diets approved by medical unit personnel creates a burden for culinary workers.

The ACA recommends written policies and procedures for special diets prescribed by medical and dental personnel. Specific diets should be prepared and served to youths according to the orders of the treating physician or dentist. Medical and dental diets should be specific,

YOUTH SERVICES

complete, provided to the food service manager in writing, and revised monthly. Special diets should be simple and should conform as closely as possible to foods served to other youth.

At one point in the inspection, the team found that 60 of 163 OHYC youths were on special diets for medical reasons. OHYC does not have written policies and procedures that govern special diets for youths nor do they have a dietitian to review requests. Requests are provided to the food service manager in writing from medical unit personnel on a Medical Alert Form. Special diets may exclude or reduce among other things, beef, pork, turkey, seafood, vegetables, dairy, sodium, fat, and carbohydrates.

The team's review of the diet request forms disclosed that a significant percentage had incomplete information. The forms were missing dates of admission, dates of alerts, specific instructions regarding diets, and dates and signatures of an approving medical authority. The team noted that there were no monthly revisions to the special diets by medical unit employees.

Additionally, the food service manager stated that a significant number of youths complain about the food served at OHYC and said they are tired of eating the same foods. Youths attend sick call and contend that they have allergies that prohibit their consumption of certain food items and are subsequently placed on medical alert status without being tested for those allergens. According to medical unit personnel, they interview youths and rely on their comments to determine the extent of their allergies and reactions to certain foods; however, they do not provide allergen testing prior to placing a youth on a special diet.

The food service manager indicated that because OHYC does not have a dietitian to approve special diets, they cannot be assured that they are preparing correct special meals based upon these medical alerts. Additionally, due to the number of youths believed to be falsifying their need for special diets, coupled with the lack of adequate testing, these requests place burdens on the food service staff by increasing the number of special meals they must prepare each day.

Recommendations:

- a. That the A/YSA coordinate with medical unit personnel and develop and implement written policies and procedures for youths with special diets.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA direct the food service manager and medical unit personnel to review all special diets and ensure that information is current, and that diets are reviewed monthly.

YOUTH SERVICES

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- c. That the A/YSA direct medical unit personnel to verify youths' medical histories and provide testing of youths for allergens prior to placing youths on special diets.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. While the Interim A/YSA agrees with the need "to verify youths' medical histories," the decision to test youth or place them on special diets should remain with medical unit personnel.

35. Large muscle exercises for youths are limited and do not comply with the Decree.

The Decree mandates that each youth participate in a range of individual and group activities to be conducted both indoors and outdoors for a minimum of 2 hours every weekday, of which 1 hour should be conducted outdoors (weather permitting). One of the hours must consist of large muscle exercise.⁴⁴ The Decree requires that accommodations be provided in the event of inclement weather, and that staff trained in therapeutic recreation supervise the youth during these activities.

The team found that youth are not participating in a full-range of large muscle exercises. Currently, the Recreation Specialist conducts exercises in the youths' housing units between the hours of 3:30 pm – 5:00 pm; however, the activities are severely limited due to insufficient space. Activities consist of ping-pong, cards, checkers, and light calisthenics. Recreation Specialists complete documentation that reflects activities participated in by youth; however, these documents do not reflect court-mandated levels of participation.

According to the Supervisory Recreation Specialist, the A/YSA discontinued allowing youth movement outside of the housing units after 5:00 p.m. effective October 6, 2003, because outside lighting is insufficient throughout the facility. There is decreased visibility, which could increase the potential risk of youth escaping.

In an effort to comply with the Decree and ensure that youth receive some large muscle activities, the Supervisory Recreation Specialist has incorporated large muscle activities into the DCPS Physical Education activities conducted in the gymnasium during school hours. However,

⁴⁴ Large muscle exercise is defined as team sports, jogging, and regular gymnasium activities.

YOUTH SERVICES

all youths do not have physical education on a daily basis and, therefore, are not participating in large muscle exercises.

Recommendations:

- a. That the A/YSA direct the Supervisory Recreation Specialist to closely monitor documentation submitted by the Recreation Specialists to ensure compliance with the Decree.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA improve the outside lighting throughout the facility to ensure that all youths are able to participate in a range of individual and group activities as mandated.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. While the Interim A/YSA agrees with the need to "improve lighting throughout the facility," such improvements must recognize the age of the facility and budget realities.

**Findings and
Recommendations:**

**ENVIRONMENTAL
HEALTH AND
SAFETY**

36. OHYC does not conduct weekly fire and safety inspections of the food service areas.

The ACA recommends that a qualified employee conduct weekly fire and safety inspections of all food service areas. The team found that OHYC does not have written policies or procedures requiring weekly fire and safety inspections and could not produce documents verifying that fire and safety inspections of the food service area have been conducted. According to the employee responsible for these inspections, these are newly acquired tasks under his purview, and he had not conducted any inspections and had not received fire and safety inspection training.

YSA cannot ensure the health and safety of youths and employees in food service areas without fire and safety inspections. In addition, without proper training, employees may overlook deficiencies or conditions that are potential fire and safety hazards.

Recommendations:

- a. That the A/YSA develop policies and procedures requiring weekly fire and safety inspections of food service areas.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA provide fire and safety inspection training for employee(s) responsible for these inspections.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

37. The Culinary Unit does not have written sanitation policies and procedures.

The ACA recommends that youth detention centers comply with and maintain applicable federal, state, and local sanitation and health codes for service operations, and have written policies and procedures for ensuring sanitation and minimizing health risks. It further recommends that an appropriate government official conduct annual inspections of the institution.

The team found that the culinary unit did not have copies of federal, state, or local sanitation and health codes for review. According to the food service manager, there were no

ENVIRONMENTAL HEALTH AND SAFETY

codes present when he assumed responsibility of the culinary unit approximately 3 years ago. He contends that the majority of OHYC food service employees are familiar with sanitation and health codes due to their varied culinary experiences.

However, the lack of readily available sanitation and health codes leaves the interpretation of codes to each food service employee and could possibly create inconsistency in the manner in which codes are implemented. This could result in a possible health risk to youth and employees, as well as violation of federal, state, and local sanitation and health codes.

Recommendations:

- a. That the A/YSA develop written sanitation policies and procedures for the food service areas.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the A/YSA obtain and distribute to each food service employee copies of applicable sanitation and health codes.

Agree X Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

38. Food service employees do not undergo annual physical examinations.

OHYC has 14 food service employees assigned to the culinary unit. ACA standards recommend that all youth center food service employees have a physical examination prior to employment, and that written policy require annual re-examinations.

The team found that YSA requires all food service employees to undergo a physical examination prior to being hired and YSA is in compliance with this requirement. The team found, however, that YSA does not have written policies and procedures requiring employees to undergo annual re-examinations. The team reviewed medical records maintained by OHYC medical personnel and found that none of the 14 food service employees had received a medical examination for 2003, although they have been employed with YSA for over a year.

OHYC medical unit personnel stated that they had not notified the food service manager that physical re-examinations were past due. Annual physical examinations ensure that food

ENVIRONMENTAL HEALTH AND SAFETY

service employees are in good health and free of communicable diseases, which might be transmitted while preparing or serving food.

Recommendation:

That the A/YSA develop and implement a written policy and procedure that requires food service employees undergo annual physical re-examinations.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The Interim A/YSA will work with OLRCB and DCOP to "develop and implement a written policy and procedure that requires food service employees undergo annual physical re-examinations."

39. OHYC does not maintain a reserve supply of food for emergencies as specified in the Emergency Response Contingency Plan.

OHYC has an Emergency Response Contingency Plan that includes an On-site Emergency Containment Plan. The proposed plan provides policies and procedures for the total containment of all youth, staff, and contract personnel in the event of an emergency. One of the plan's provisions is designed to ensure that OHYC can provide food and shelter for a period of 3-5 days for a maximum of 430 persons during "any event or situation that is declared by the D.C. Department of Fire & Emergency Medical Services (DC/FEMS), as an emergency." The proposed plan also requires that emergency food be stored in a walk-in freezer in the Central Administration Building.

The team found that the culinary unit is not prepared to provide food in the event of an emergency that requires total containment of the institution. Food items have not been procured, power to the freezer has been shut off, and the freezer contained furniture and supply items.

Consequently, OHYC cannot comply with the requirements of the Emergency Response Contingency Plan.

Recommendation:

That the A/YSA expedite the procurement of emergency food items in accordance with the Emergency Response Contingency Plan.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

ACA recommends that youth detention facilities have established environmental, health, and safety standards that comply with applicable federal, state, and local codes and regulations. ACA recommends that, among other things, youth detention facilities:

- The inspection team found that these standards are not being met and found the following specific conditions:

- YSA officials stated that many of the conditions are due to the age of the facility. OHYC is an aging facility and is in need of structural, electrical, plumbing, and air-conditioning repairs. However, due to inadequate repairs and maintenance, YSA cannot ensure the health and safety of residents, employees, and visitors at OHYC.

That the A/YSA request an inspection of OHYC by the District of Columbia Office of Risk Management to determine whether there are any physical hazards to residents, employees and visitors, and if so, what measures should be taken to address such hazards.

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The Interim A/YSA will request "an inspection of OHYC by the District of

ENVIRONMENTAL HEALTH AND SAFETY

Columbia Office of Risk Management” once YSA’s Deputy Administrators for Support Services (Chief Administrative Officer) and Secure Programs have been hired.

**Findings and
Recommendations:
ADMINISTRATION**

- improved staff training and development;
- assessment of program strengths and weaknesses;
- defense against lawsuits;
- establishment of measurable criteria for upgrading operations;
- improved staff morale and professionalism;
- safer environment for staff and offenders;
- reduced liability insurance costs; and
- performance-based benefits.⁴⁵

The team found that OHYC is not an accredited youth detention facility, and there are no District regulations requiring inspection, accreditation, or independent evaluation of the facility.

Recommendations:

- a. That the A/YSA take the necessary steps to have OHYC inspected and evaluated by the ACA.

Agree **X** Disagree

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The MOU between DHS and DOC requires that DOC facilitate contact on YSA's behalf with ACA. While the Interim A/YSA understands and agrees with the need "to have OHYC inspected and evaluated by the ACA," taking steps to have the facility accredited does not

⁴⁵ See www.aca.org.

make sense where the Blue Ribbon Commission has recommended construction of a new facility and demolition of the old facility.

- b. That the A/YSA work with the City Council and the Mayor in proposing legislation requiring OHYC to become an accredited facility.

Agree _____ Disagree _____ **X** _____

DHS's Response to IG's Recommendation, as Received:

The MOU between DHS and DOC requires that DOC facilitate contact on YSA's behalf with ACA. While the Interim A/YSA understands and agrees with the need "to have OHYC inspected and evaluated by the ACA," proposing legislation to require accreditation of the facility does not make sense where the Blue Ribbon Commission has recommended construction of a new facility and demolition of the old facility. Instead, the Interim A/YSA proposes that such efforts be concentrated on the new Youth Services Center and that the experience be used to seek accreditation of a newly-constructed OHYC.

OIG Response: **OIG stands by recommendation as stated.**

42. The Institutional Review Committee, an important quality assurance mechanism within YSA, is not active.

A BCCS case manager and an OHYC treatment team leader share case management responsibilities for committed youths housed at OYHC. Such shared oversight makes disagreements over case management issues inevitable. YSA's Institutional Review Committee (IRC) was established to serve as a quality assurance mechanism with authority to make final decisions on case management disputes that arise between BCCS and OHYC case managers. The IRC also resolves disputes about treatment and placement decisions, home visits, and the appropriate level of aftercare supervision. According to the case management manual, the IRC should serve as a resource to the OHYC treatment teams by reviewing cases upon request and providing direction to the teams.

The IRC should consist of four members: the OHYC Superintendent, the OHYC Director of Mental Health Services, the Oak Hill Academy Director, and BCCS's Division of Social Services Chief. IRC decisions must be made by consensus and a record must be kept of all cases reviewed and decisions rendered. With respect to timeframes, the manual states the IRC must conduct a hearing within 5 working days of receipt of a request for IRC review. In addition to mediating professional disagreements, the IRC should also play a role in evaluating each caseworker's performance.

The team found that the IRC is not a standing, active committee, and that it has not met for a number of months. Personnel turnovers and attrition at YSA have contributed to the inactivity of the IRC. As a result, treatment disputes between case managers are not being reviewed and resolved in a timely manner. In addition, the absence of the IRC represents a gap in

quality assurance and the ability of YSA to evaluate the work of the treatment team leaders based on the observations of multi-disciplinary group.

Recommendation:

That the A/YSA immediately reactivate the Institutional Review Committee.

Agree X Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The OHYC Assistant Superintendent for Treatment previously reactivated the Institutional Review Committee.

43. YCOs are not signing in and out on the Daily Sign-In/Out Sheet as required.

The YSA Human Resources Manager requires that Time and Attendance (T&A) Clerks verify an employee's presence or absence from work either by verification of the Daily Sign-In/Out Sheets, Shift Operations Reports⁴⁶, or a D.C. Standard Form 71 (Application for Leave).

A YSA internal policy memorandum dated November 27, 2000, to OHYC security personnel, states that "[e]ffective 27 November 2000, you will sign in when reporting for duty and sign-out at the completion of your tour of duty."

Each day the Administrative Assistant to the Deputy Administrator for Program Operations collects and forwards all T&A support documentation⁴⁷ to the Human Resources Manager for processing. Prior to the approval and authorization of payment, the T&A Clerk must verify the authenticity of the documents and ensure that documents submitted are accurate, i.e., if an employee is listed on the Shift Operations Report, that employee should have signed the Daily Sign-In/Out Sheet.

Daily Sign-In/Out Sheets are forwarded to the T&A Clerk for inclusion in payroll processing. The team noted that YCOs are not signing the Daily Sign-In/Out Sheets upon arrival to work and upon completion of their tour of duty. YCOs failure to sign the Daily Sign-In/Out Sheets makes it difficult for the Time and Attendance Clerk to verify their presence at work on specific dates and to verify the number of hours worked. Delays in processing occur because the T&A Clerk must seek other means to verify YCOs presence at work and the number of hours worked on specific dates. Failure to adhere to this policy creates a potential for T&A fraud.

Recommendations:

⁴⁶ Shift Roster that indicates each employee's name and the posts employees worked that day.

⁴⁷ Support documentation includes Shift Operations Reports from each shift, Requests for Authorization of Overtime Work, YCOs' Requests for Overtime/Compensatory Time Sign-In/Out Sheet, and Applications for Leave.

ADMINISTRATION

- a. That the Officers-of-the-Day ensure that all YCOs sign the Daily Sign-In/Out Sheets upon their arrival and departure from work.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

- b. That the Officers-of-the-Day review the Daily Sign-In/Out Sheets for signatures and obtain any missing signatures prior to forwarding the sheets to the T&A Clerk.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings.

44. YCOs are exceeding the 24-hours-per-pay-period limit on working overtime.

YSA has an internal policy that limits the amount of overtime YCOs can work per pay period to 24 hours. YCOs who have met this limit should normally not be permitted to work additional hours.

An OHYC internal policy memorandum, dated August 21, 2001, states that "All security personnel that have met the 24-hour limit for overtime will not be able to work additional overtime unless it have [sic] been approved by Superintendent or his designee." In addition, the policy requires YCOs to request approval from the Officer-of-the-Day or the Shift Supervisor before exceeding the 24-hour overtime limit.

The YSA Human Resources Manager tracks the total number of overtime hours worked by each YCO who is close to meeting or who has exceeded the 24-hour limit and provides a daily Overtime Tracking Report to the Deputy Administrator for Program Operations.

The team reviewed the Overtime Tracking Reports and the Overtime Comparison Chart, and determined that YCOs are consistently exceeding the 24-hour limit by averaging 30-60 overtime hours per pay period.

The lack of policy enforcement by the Deputy Administrator and Officers-of-the-Day has allowed YCOs to consistently exceed the limit.

Recommendation:

ADMINISTRATION

That the A/YSA enforce compliance with the 24-hours-per-pay-period limit on overtime worked by YCOs.

Agree _____ **X** _____ Disagree _____

DHS's Response to IG's Recommendation, as Received:

By agreeing with this recommendation, DHS does not necessarily agree with OIG's factual findings. The Acting OHYC Superintendent, Officers-of-the-Day, and the Human Resources Manager already are enforcing compliance with 24-hours-per-pay-period limit on overtime.

45. YSA is not complying with training and staff development programs at OHYC as required by the Decree.

YSA is required under the Decree to comply with the standards of the ACA pertaining to training and staff development. These standards require that employees with regular or daily contact with juveniles receive an additional 40 hours of training each year of employment subsequent to the year they were hired. This training allows employees to sharpen skills and keep abreast of changes in operational procedures.

ACA states that the following job descriptions of general job categories should be used in determining minimum training requirements:

| Category | Typical Position Titles | Training Hours First Year on the Job | Training Hours Each Year Thereafter |
|--|---|--------------------------------------|-------------------------------------|
| Clerical/Support (Minimum Contact with youth) | Secretaries, Clerks, Typists, Computer/Warehouse Personnel, Accountants, Personnel Staff | 16 | 16 |
| All Child Care/Supervision Staff | All staff assigned to full-time child care and/or supervision duties, security officers | 120 | 40 |
| Administrative/Management Personnel | Superintendents, Deputy or Assistant Superintendents, Business Managers, Personnel Directors, Child Care Supervisors, Shift Supervisors | 80 | 40 |

APPENDICES

APPENDICES

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|---------------------|--------------------------------------|
| Appendix 1: | List of Findings and Recommendations |
| Appendix 2: | MAR 03-I-011 |
| Appendix 3: | Response to MAR 03-I-011 |
| Appendix 4: | MAR 03-I-007 |
| Appendix 5: | Response to MAR 03-I-007 |
| Appendix 6: | MAR 03-I-006 |
| Appendix 7: | Response to MAR 03-I-006 |
| Appendix 8: | MAR 03-I-008 |
| Appendix 9: | Response to MAR 03-I-008 |
| Appendix 10: | MAR 03-I-009 |
| Appendix 11: | Response to MAR 03-I-009 |
| Appendix 12: | MAR 03-I-010 |
| Appendix 13: | Response to MAR 03-I-010 |
| Appendix 14: | MAR 03-I-013 |
| Appendix 15: | Response to MAR 03-I-013 |

Appendix 1

LIST OF FINDINGS AND RECOMMENDATIONS

Key Findings:

1. **Long-standing deficiencies in the management of OHYC and in attempts to comply with the Jerry M. Consent Decree continue to plague YSA despite millions spent on consultants.**
 - a. That the Mayor give immediate consideration to removing YSA from DHS and forming a separate, cabinet-level agency whose Director reports to and is directly and sufficiently overseen by the Deputy Mayor for Children, Youth, Families, and Elders (DMCYFE).
 - b. That the DMCYFE and Administrator of YSA (A/YSA) take immediate action to address the most urgent problems cited in the Key Findings section of this report and in reports by paid consultants, particularly issues of security, safety, health, and illegal substances.
 - c. That the DMCYFE and A/YSA fully participate in the Performance-based Standards (PbS) system¹ for juvenile facilities that has been developed by the Council of Juvenile Correctional Administrators under the sponsorship of the U.S. Justice Department.
2. **YSA's use of consultants has been largely ineffective and characterized by unauthorized overspending, incomplete deliverables, unfulfilled objectives, and poor agency oversight.**

That the A/YSA, in order to minimize the duplication of previous efforts, coordinate a review and prioritization of all policies, procedures, assessments and recommendations produced by past consultants, and identify those deliverables that can be salvaged and implemented.
3. **Illegal substances such as marijuana and PCP are smuggled into OHYC regularly.**
 - a. That the A/YSA request that the DHS Office of Investigations and Compliance (OIC) investigate allegations by staff members that YCOs are transporting illegal substances into OHYC. The Director of DHS should report the results of that investigation to the Inspector General, and to other government entities as may be required by District, Maryland, or federal law.
 - b. That the A/YSA explore the feasibility of implementing a canine drug detection program for illegal substances at OHYC.

¹ The Performance-based Standards (PbS) system was developed by the Council of Juvenile Correctional Administrators at the request of the Department of Justice to help youth correction and detention facilities continuously improve conditions of confinement and services provided. PbS is described as a tool that agencies can integrate into existing operations to develop, monitor, and sustain improvement. Details can be found at <http://www.performancebasedstandards.org>.

LIST OF FINDINGS AND RECOMMENDATIONS

4. **OHYC does not have a substance abuse treatment program as required by the Decree, and is in jeopardy of failing to qualify for federal grant funding.**

That the A/YSA expedite the procurement of a contract to provide drug educational and counseling services as required by the Decree and ensure that YSA is eligible to apply for the federal grant funding.

5. **Contract security guards allowed serious security breaches at entrances to the OHYC Detention Facility.**

- a. That the A/YSA provide adequate policies, procedures, and training for security guards to ensure that proper searches of all bags and packages of visitors and employees entering the secure detention facility are conducted.
- b. That the A/YSA provide adequate policies, procedures and training for security guards to ensure that effective frisk and pat search procedures are conducted on visitors and employees entering the secure detention facility.
- c. That the A/YSA ensure that the gatehouse metal detector is operational and in use at all times.
- d. That the A/YSA ensure that at least two security guards are present at the perimeter entrance gate and that guards adhere to all entrance security procedures.
- e. That the A/YSA take immediate action to have the front gate restroom facilities repaired so that guards will not have a reason to leave the post unsecured.

6. **YSA does not conduct adequate and timely background checks on those who must have regular contact with youths.**

- a. That the A/YSA ensure that all current employees with regular contact with youths and all applicants undergo a MPD criminal background check as required by current policy.
- b. That the Director of the Department of Human Services propose legislation to the Mayor that would require and fund a complete background check for appropriate OHYC and other YSA employees, to include a check of the records at MPD and surrounding law enforcement jurisdictions, an NCIC check, and a review of the Central Registry of Crimes Against Children/Sex Offenders.

7. **YSA vehicles are being operated with expired inspection stickers and without semi-annual preventive maintenance checks in violation of District Regulations.**

- a. That the A/YSA ensure that all vehicles are properly inspected in accordance with District Municipal Regulations.

LIST OF FINDINGS AND RECOMMENDATIONS

- b. That the A/YSA discontinue the use of vehicles that do not contain valid inspection stickers.
- c. That the A/YSA ensure that semi-annual preventive maintenance checks are conducted on all YSA vehicles.
- d. That A/YSA coordinate with DPW to either increase staffing levels for mechanics assigned to OHYC or allot additional days per week for the DPW mechanic to service and maintain YSA's fleet of vehicles.

8. YSA employees are operating government vehicles without valid state driver's licenses and government motor vehicle identification cards.

That the A/YSA ensure that all vehicle operators maintain current state driver's licenses and D.C. Government Motor Vehicle Identification Cards.

9. YCOs and transportation officers lack adequate communication equipment.

- a. That the A/YSA ensure that each YCO on-duty at OHYC has a functional two-way radio for the duration of his or her shift.
- b. That the A/YSA ensure that wired telephones are repaired or replaced so that the YCO office in each housing unit has a working telephone.
- c. That the A/YSA provide additional telephones in each housing unit (i.e., a phone other than the one in the YCO office) to accommodate the youths' biweekly telephone calls.
- d. That the A/YSA ensure that at least one transportation officer in addition to the driver is provided with a radio or cellular telephone in order to communicate with the OHYC security control office or with outside public safety agencies.
- e. That the A/YSA discontinue the practice of allowing youths to use telephones in the YCO offices.

10. Not all staff members in the Social Services department have working telephones and voicemail.

That the A/YSA ensure that employees in the Social Services department (TTLs, SSRs, and their supervisors) have functioning telephones and voice mailboxes.

11. Inadequate security equipment in the female housing unit impedes YCOs' effectiveness and creates potential hazards.

- a. That the A/YSA ensure that each YCO on duty in Unit 6 has a functional two-way radio for the duration of his or her shift.

LIST OF FINDINGS AND RECOMMENDATIONS

- b. That the A/YSA ensure that a working telephone is installed in the YCO security office.
- c. That the A/YSA ensure that an emergency buzzer, direct phone line, or other notification device is connected between Unit 6 and the OHYC security control center to provide an alternative means of immediate communication in the event of an emergency.
- d. That the A/YSA ensure that all electronic security monitoring equipment is repaired or replaced.
- e. That the A/YSA ensure that YCOs keep the metal detector activated at all times, that batteries are installed in the hand scanner, and that the scanner is used in accordance with procedures.
- f. That the A/YSA ensure the installation of adequate lighting for the exterior building perimeter.
- g. That the A/YSA ensure that sufficient air conditioning and heating are provided in the YCO security office.

12. The ratio of youths to YCOs exceeds Decree requirements.

That the A/YSA take the necessary steps to ensure compliance with the youth to YCO ratio.

13. Serious fire safety deficiencies may put residents and employees at risk.

- a. That the A/YSA ensure that all employees have access to fire extinguishers at all times.
- b. That the A/YSA ensure that the fire extinguishers in the gymnasium are removed from the closet and re-installed on the wall mounts.
- c. That the A/YSA ensure that all deficiencies cited by the FEMS Fire Prevention Bureau are abated immediately.
- d. That the A/YSA ensure that emergency evacuation plans are posted publicly in all key areas of OHYC.
- e. That the A/YSA ensure that fire drills are conducted and documented quarterly as required.
- f. That the A/YSA hire a trained Health and Safety Officer or provide adequate training to the designated OHYC employee who conducts monthly fire safety inspections.

LIST OF FINDINGS AND RECOMMENDATIONS

- g. That the A/YSA explore the feasibility of a central locking system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency.
- h. That the A/YSA ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.

14. Numerous abandoned buildings at OHYC are unsecured and vandalized.

- a. That the A/YSA ensure that each abandoned building at the OHYC is secured against vandalism and safety risks.
- b. That the A/YSA ensure that utility service to unused buildings is disconnected.

15. OHYC is not reporting unusual incidents to the DHS Office of Investigations and Compliance as required.

That the A/YSA develop a system to ensure that all unusual incidents are promptly reported to DHS OIC.

16. YSA's fiscal and asset management has many deficiencies.

- a. That the A/YSA and the District's Chief Procurement Officer conduct a review and audit of all YSA contracts for FY 2003 and 2004 to ensure compliance with District contracting and procurement regulations.
- b. That the A/YSA request that OCP and OCFO conduct an audit of the D.C. Purchase Card Program at YSA.
- c. That the A/YSA develop and enforce policies and procedures to ensure control and accountability of warehouse operations, and ensure that a qualified employee is in charge.

17. Deficiencies within YSA's Information Technology (IT) infrastructure may impair YSA's ability to effectively manage its day-to-day operations.

- a. That the A/YSA expedite meetings of representatives from DHS's Office of Information Systems, the District's Office of the Chief Technology Officer (OCTO), and YSA, to discuss engaging OCTO technical expertise until YSA employees can be sufficiently trained on JIMS.
- b. That A/YSA give priority to ensuring that JIMS is made capable of producing all reports necessary for supporting OHYC supervision and tracking of detained and committed youths, as well as statistical information required by the court and other entities with a vested or otherwise appropriate interest in YSA operations.

LIST OF FINDINGS AND RECOMMENDATIONS

- c. That the A/YSA provide all departments at OHYC with reliable, secure access to JIMS.
- d. That the A/YSA ensure that all JIMS users receive appropriate training and ongoing IT support.

Security:

18. YSA does not have policies, procedures, or staff to handle an escape from OHYC.

- a. That the A/YSA ensure that thorough and complete escape procedures are drafted, implemented, and distributed to all key personnel.
- b. That the A/YSA ensure that adequately trained staff are available at OHYC to be mobilized in the event of an escape.

19. YCOs have not had emergency response training.

- a. That the A/YSA ensure that all YCOs receive a copy of the Hazard Continuity and Contingency Plan.
- b. That the A/YSA ensure that YCOs receive emergency response training.

20. Youths are not photographed when remanded to YSA's custody.

That the A/YSA ensure that each youth is photographed upon arrival at OHYC, and that a copy of this photograph be filed as required.

21. The number and location of physical restraints are not accounted for and OHYC officials are not effectively monitoring their use.

That the A/YSA follow established policies and procedures regarding the inventory and use of physical restraints.

22. Some OHYC electronic monitoring systems are inoperative.

That the A/YSA ensure that all electronic monitoring systems at OHYC are repaired and maintained.

23. The door to the gatehouse control booth is not secured, which compromises facility security.

- a. That the A/YSA ensure that the hinges on the gatehouse control booth door are repaired.

LIST OF FINDINGS AND RECOMMENDATIONS

- b. That the A/YSA develop policies and procedures to ensure that the gatehouse control booth door remains locked and secured at all times.
- c. That the A/YSA discontinue the storage of physical restraints in the gatehouse control booth area.

24. Policy and procedures manuals are not available in 9 of 11 youth housing units.

- a. That the A/YSA develop up-to-date policies and procedures that govern daily housing unit operations.
- b. That the A/YSA ensure dissemination of an updated policy and procedures manual to all housing units and to all personnel as appropriate.
- c. That the A/YSA ensure that policies and procedures are updated and distributed annually as recommended by ACA.

Youth Services:

25. Project Hands does not complete investigative reports within the 10-day requirement.

That the Director of DHS take necessary actions to ensure that the 10-day investigative report requirement is met.

26. YSA's drug screening program has serious deficiencies.

- a. That the A/YSA establish written policies and procedures for drug testing and a training program for collectors of urine specimens.
- b. That the A/YSA establish a chain of custody for the urine collection process.
- c. That the A/YSA ensure that accurate records are kept of the drug screening process.

27. YSA staff members are constrained by unrealistic diagnostic and reporting deadlines.

That the A/YSA discuss with the Office of the Corporation Counsel the feasibility of a meeting with the court-appointed monitors and the Decree plaintiffs' attorneys to negotiate an extension of the diagnostic timeframe and reporting requirements in order to ease the administrative burden created by the current treatment plan deadlines.

28. Administrative support for OHYC treatment team leaders is insufficient.

LIST OF FINDINGS AND RECOMMENDATIONS

That the A/YSA expedite the hiring of additional personnel to adequately support the treatment team leaders.

29. Poor communication between departments at OHYC impedes the coordination of services and the treatment of youths.

That the A/YSA reinstate the practice of convening a meeting of all OHYC department heads on, at minimum, a monthly basis.

30. Parent participation in diagnostic and treatment team meetings is extremely low.

- a. That the A/YSA procure telephone equipment and service in the room where the weekly treatment team meetings are held so that parents will be able to participate in these meetings via teleconference.
- b. That the A/YSA lead an initiative, staffed by members from all of OHYC's major departments, to identify additional ways to improve parent participation in the treatment team process.

31. OHYC home visitation policies are not uniformly applied.

That the A/YSA ensure that the home visitation policy is reviewed and is more uniformly applied.

32. OHYC does not have a dietician to ensure compliance with nationally recommended daily food allowances.

That the A/YSA hire a full-time dietician or a dietary consultant to review menus and ensure compliance with federally recommended daily food allowances.

33. OHYC does not have written policies and procedures for youths who require special diets due to religious dietary standards.

That the A/YSA seek either internal or external expertise in developing written policies and procedures for dietary plans for youths with religious beliefs that require special diets.

34. The number of special diets approved by medical unit personnel creates a burden for culinary workers.

- a. That the A/YSA coordinate with medical unit employees and develop and implement written policies and procedures for youths with special diets.

LIST OF FINDINGS AND RECOMMENDATIONS

- b. That the A/YSA direct the food service manager and medical unit personnel to review all special diets and ensure that information is current, and that diets are reviewed monthly.
- c. That the A/YSA direct medical unit personnel to verify youths' medical histories and provide testing of youths for allergens prior to placing youths on special diets.

35. Large muscle exercises for youths are limited and do not comply with the Decree.

- a. That the A/YSA direct the Supervisory Recreation Specialist to closely monitor documentation submitted by the Recreation Specialists to ensure compliance with the Decree.
- b. That the A/YSA improve the outside lighting throughout the facility to ensure that all youths are able to participate in a range of individual and group activities as mandated.

Environmental Health And Safety:

36. OHYC does not conduct weekly fire and safety inspections of the food service areas.

- a. That the A/YSA develop policies and procedures requiring weekly fire and safety inspections of the food service areas.
- b. That the A/YSA provide fire and safety inspection training for the employee(s) responsible for these inspections.

37. The Culinary Unit does not have written sanitation policies and procedures.

- a. That the A/YSA develop written sanitation policies and procedures for the food service areas.
- b. That the A/YSA obtain and distribute to each food service employee copies of applicable sanitation and health codes.

38. Food service employees do not undergo annual physical examinations.

That the A/YSA develop and implement a written policy and procedure that requires food service employees undergo annual physical re-examinations.

39. OHYC does not maintain a reserve supply of food for emergencies as specified in the Emergency Response Contingency Plan.

That the A/YSA expedite the procurement of emergency food items in accordance with the Emergency Response Contingency Plan.

LIST OF FINDINGS AND RECOMMENDATIONS

40. OHYC has not been inspected for environmental, health, and safety deficiencies.

That the A/YSA request an inspection of OHYC by the District of Columbia Office of Risk Management to determine whether there are any physical hazards to residents, employees and visitors, and if so, what measures should be taken to address such hazards.

Administration:

41. OHYC is not an accredited youth detention facility.

- a. That the A/YSA take the necessary steps to have OHYC inspected and evaluated by the ACA.
- b. That the A/YSA work with the City Council and Mayor in proposing legislation requiring OHYC to become an accredited facility.

42. The Institutional Review Committee, an important quality assurance mechanism within YSA, is not active.

That the A/YSA immediately reactivate the Institutional Review Committee.

43. YCOs are not signing in and out on the Daily Sign-In/Out Sheet as required.

- a. That the Officers-of-the-Day ensure that all YCOs sign the Daily Sign-In/Out Sheets upon their arrival and departure from work.
- b. That the Officers-of-the-Day review the Daily Sign-In/Out Sheets for signatures and obtain any missing signatures prior to forwarding the sheets to the T&A Clerk.

44. YCOs are exceeding the 24-hours-per-pay-period limit on working overtime.

That the A/YSA enforce compliance with the 24-hours-per-pay-period limit on overtime worked by YCOs.

45. YSA is not complying with training and staff development programs at OHYC as required by the Decree.

That the A/YSA take the necessary steps, to include appropriate administrative action, to ensure that all affected employees meet the training requirements as set forth in the Decree.

Appendix 2



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
AUSTIN A. ANDERSEN
INTERIM INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

**ILLEGAL SUBSTANCES AT OAK HILL YOUTH
CENTER**

MAR 03 – I - 011
JANUARY 7, 2004

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



January 7, 2004

Yvonne D. Gilchrist
Director
Department of Human Services
2700 Martin Luther King Jr. Ave., SE
801 East Building
Washington, DC 20032

Marceline D. Alexander
Acting Administrator
Youth Services Administration
8300 Riverton Court
Laurel, MD 20724

Dear Ms. Gilchrist and Ms. Alexander:

This is a Management Alert Report (MAR 03-I-011) to inform you of a significant issue that has come to our attention as a result of our inspection of the Department of Human Services (DHS), Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of District of Columbia government officials. The inspection team (team) has received information indicating that illegal substances, such as marijuana and phencyclidine (PCP), are smuggled into the Oak Hill Youth Center (OHYC) in Laurel, Maryland on a continual basis.

Background

According to YSA officials, nearly 100% of OHYC detained youths (residents) suffer from substance abuse problems. The Jerry M. Consent Decree requires YSA to provide treatment programs to assist residents in recovering from these problems. Treatment cannot be meaningful or effective, however, if residents continue to have access to illegal substances.

Observation

A number of OHYC employees interviewed by the team stated that the presence of illegal substances has been an ongoing problem for a number of years. The team reviewed a random sample of drug test results, and found that numerous residents who tested negative for drug use

upon arrival at OHYC tested positive for marijuana and PCP after being confined. Employees believe that Youth Correctional Officers (YCOs) are the primary source of the illegal substances used by youths in OHYC, and that the lack of proper security checks at the entrance has allowed them, and presumably others, to carry in contraband past the security guards.

The availability of illegal substances such as marijuana and PCP in OHYC hinders treatment and recovery of residents with pre-existing substance abuse problems, and creates addiction and other health problems for others.

Recommendations

YSA has taken measures to upgrade the OHYC security force, and that action should improve the detection of contraband such as illegal drugs at OHYC entrances. However, OIG recommends that the YSA Administrator initiate the following actions:

1. Request that the DHS Office of Internal Compliance investigate allegations by staff members that YCOs are transporting illegal substances into OHYC. The Director of DHS should report the results of that investigation to the Inspector General, and to other government entities as may be required by District, Maryland, or federal law; and
2. Explore the feasibility of implementing a canine detection program for illegal substances at OHYC.

Please provide your comments on this MAR by January 20, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report only to those personnel who will be directly involved in preparing your response. Should you have questions or desire a conference prior to preparing your response, please contact Lawrence Perry, Director of Planning and Inspections, at 202-727-8490.

Sincerely,



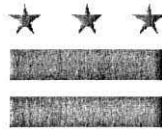
Austin A. Andersen
Interim Inspector General

AAA/lp

cc: Robert C. Bobb, City Administrator
Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders
James Parks, Deputy Director for Administration, DHS
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

Appendix 3

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Human Services
Youth Services Administration



Marceline D. Alexander
Interim Administrator

February 13, 2004

Mr. Austin A. Anderson
Interim Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

RE: *Management Alert Report 03-I-011 (Illegal Substances at Oak Hill Youth Center)*

Dear Mr. Anderson:

This correspondence is transmitted to you in response to Management Alert Report 03-I-011 dated January 7, 2004, in which the Office of the Inspector General ("OIG") makes two recommendations to the Youth Services Administration ("YSA") in connection with actions to improve the detection of contraband such as illegal substances at the Oak Hill Youth Center ("OHYC"). Specifically, OIG states as follows:

YSA has taken measures to upgrade the OHYC security force, and that action should improve the detection of contraband such as illegal drugs at OHYC entrances. However, OIG recommends that the YSA Administrator initiate the following actions:

1. Request that the DHS Office of Internal Compliance investigate allegations by staff members that YCOs are transporting illegal substances into OHYC. The Director of DHS should report the results of that investigation to the Inspector General, and to other government entities as may be required by District, Maryland, or federal law; and
2. Explore the feasibility of implementing a canine detection program for illegal substances at OHYC.

YSA appreciates the acknowledgement in your letter that we already have taken affirmative steps to address the presence of illegal substances at OHYC. We agree that the use of Department of

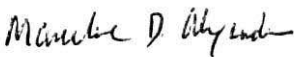
Corrections officers to provide perimeter and sally port security at OHYC on YSA's behalf will assist us in the interdiction of contraband entering the facility.

In response to your specific recommendations, please be advised as follows:

- DHS Director Yvonne D. Gilchrist has directed the Office of Investigations and Compliance to investigate allegations by YSA staff members that YCOs are transporting illegal substances into OHYC. Denise E. Nedab, OIC Chief, may be consulted with respect to the specific timetable for completion of its investigation of these serious allegations.
- As an interim measure, YSA currently is exploring the feasibility of working with the Metropolitan Police Department ("MPD"), the U.S. Park Police, the Anne Arundel County Police, or the Prince George's County Police to use the OHYC as an extension of their respective canine training programs to buttress YSA's drug interdiction measures inside of the facility. These police would be asked to periodically visit OHYC as part of the practical application of their canine training program. The longer range objective is to enter into a memorandum of understanding with MPD to provide OHYC and subsequently, the new Youth Diagnostic Center, with a permanent canine detection program. It is too earlier in these discussions to provide a specific timeline.

Should you have any questions regarding these responses, please contact Clydie A. Smith, Correctional Program Officer, Youth Services Administration, at (240) 456-5005.

Sincerely,


Marceline D. Alexander
Interim Administrator

MDA/cas

cc: Robert C. Bobb, City Administrator
Lori E. Parker, Acting Deputy Mayor for Children, Youth, Families and Elders
Yvonne D. Gilchrist, DHS Director
Vanessa Chappell-Lee, DHS Deputy Director
Mark D. Back, YSA Interim Special Counsel
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

Appendix 4



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

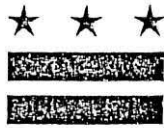
**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

**SECURITY BREACHES AT OAK HILL YOUTH
CENTER**

MAR 03 – I - 007
OCTOBER 9, 2003

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



October 9, 2003

Leticia Lacomba
Acting Administrator
Department of Human Services
Youth Services Administration
8300 Riverton Court
Laurel, MD 20724

Jacques Abadie, III
Chief Procurement Officer
Office of Contracting and Procurement
441 4th Street NW
Suite 800S
Washington, DC 20001

Marceline Alexander
Interim Director
Office of Property Management
441 4th Street NW
Suite 1100S
Washington, DC 20001

Dear Ms. Lacomba, Mr Abadie, and Ms. Alexander:

This is a Management Alert Report (MAR 03-I-007) to inform you of significant issues that have come to our attention as a result of our inspection of the Department of Human Services, Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia (District) government official.

Background:

The inspection team (team) observed serious breaches of security at entrances to the Oak Hill Detention Facility in Laurel, Maryland. These entrances are staffed by contract security guards employed through the District's Office of Contracting and Procurement (OCP). The team

found that the Office of Property Management's (OPM) Protective Services Division is responsible for monitoring security services under this contract. Because the security guards are hired through OCP and monitored by OPM, YSA management exercises no direct supervision. According to YSA management, neither OCP nor OPM adequately monitor the performance of the security guards, and the current contract does not permit YSA management to take disciplinary action against guards who violate security policies and procedures, even when an infraction is fully documented.

The team found that the contracted security guards are responsible for:

- preventing the entrance of contraband¹ into the detention facility through the use of effective package searches, metal detector screenings, and frisks or pat searches; and
- controlling the perimeter of the facility by preventing unauthorized persons and/or vehicles from entering the facility by obtaining proper identification and registering all non-YSA employees and vehicles.

Observations:

1. Security guards do not thoroughly search bags, packages, containers, and other personal items of employees and visitors entering the secure detention facility. Consequently, searches of the residential areas frequently reveal contraband such as marijuana, lighters, cigarettes, and videotapes.

YSA management has posted a sign at the gatehouse of the secured detention facility advising visitors and employees that all packages are subject to search. A list of contraband items not permitted in the facility is also posted at the entrance (Attachment A).

The team found, however, that the security guards are performing only cursory searches of items such as bags, briefcases, and purses brought into the facility by staff and visitors. On numerous occasions, the security guards failed to open and search these containers, and contraband items such as cell phones, non-prescription drugs, pornographic materials, and items that could be used as weapons, were allowed through the security checkpoint. YSA employees stated that knives and ice picks have been carried through the checkpoint. In addition, drugs such as marijuana and PCP are entering the facility due to the lack of proper searches, resulting in a large number of residents testing positive for illegal substances during random drug testing.

¹ YSA defines contraband as articles prohibited under law applicable to the general public that are readily capable of being used to cause death or serious physical injury, such as firearms, cartridges, knives, explosives, or illegal drugs. These items are prohibited by the rules and regulations of the facility and, when possessed by a resident without authorization, are considered contraband and are seized.

2. The metal detector at the gatehouse is not always used.

The American Correctional Association (ACA), Standards for Juvenile Correction Facilities recommends the use of metal detectors at entrance gates. YSA uses a walk-through metal detector similar to those found at airports, and employees and visitors are required to walk through the metal detector prior to entering the secure facility.

The team observed on numerous occasions, however, that the security guards failed to activate the metal detector, as visitors walked through unchecked. Also, visitors and employees are not required to take bags, purses, briefcases or packages through the metal detector. As a result, those with guns, knives or metal objects that could be used as weapons can gain access to the facility undetected.

3. Security guards are not using effective frisk or pat search procedures on employees and visitors.

All visitors are advised that they will be subject to a frisk or pat search of their clothing prior to entering the facility. The Deputy Administrator stated that all employees are also subject to a frisk or pat search. YSA provided the team with general guidelines for conducting a frisk or pat search (Attachment B).

The team found that security guards only conduct cursory searches by lightly running their hands over the shoulders, arms, sides of the body, and the sides of legs of those who enter the facility. Security guards also do not require visitors or employees to empty their pockets when items that might be questionable are detected. The team observed numerous occasions when no frisk or pat down of any visitor or employee was conducted.

Security guards stated that they do not have a correctional facility background, have not been provided written guidelines for conducting frisk or pat searches, and have not been trained by either the security company or YSA. Several security guards stated that former employees provided only verbal instructions on the frisk and pat search procedures.

4. Control of pedestrians and vehicles entering the front gate is inadequate and sometimes negligent.

ACA standards recommend that pedestrians and vehicles enter and leave a secure facility at designated points on the perimeter. Those designated points should be controlled by appropriate means to prevent access without proper authorization.

YSA maintains one security guard at the entrance of Oak Hill to monitor all vehicles and pedestrians entering the facility. This employee is required to manually open and close the security gates, register the vehicle license plates of all non-YSA and non-government employees, and obtain positive identification of all non-YSA employees. The inspection team found that on numerous occasions there was no security guard present at this entrance, and the security gates had been left open and unattended because the guard left to use a restroom located across the

street from the entrance. (Restroom facilities inside the front gate security trailer have been out of service since 2001.) On other occasions, the team observed the security guard sitting in the guard trailer, using the telephone, and allowing vehicles to enter and exit the open security gate at will.

YSA's Internal Operations Manager indicated that he has requested that the security company provide additional staffing for the front gate, but the contracting company denied this request, apparently because OCP has not provided funding for additional staffing at this post.

5. Contract security guards are working without completed criminal record checks.

ACA standards recommend that a criminal record check be conducted on all new employees, prior to hire, in accordance with state and federal statutes to ensure that facility administrators know of any criminal conviction that could directly affect an employee's job performance. YSA similarly requires that all employees with access to the Oak Hill secure detention center and who have regular contact with detained residents, undergo a criminal record check and be cleared prior to being hired.

However, the team found that YSA security guards are permitted to work for 90 days prior to obtaining clearance from their contracting company. When hired by the company, they receive temporary work identification cards, report to their post at YSA, and are told to return in 90 days to obtain the results of criminal record checks. If a criminal record check comes back after 90 days noting convictions, the security guard is no longer permitted to work at YSA. The Human Resources Manager stated that because the security guards are not YSA employees, she is not authorized to conduct criminal record checks independently of those obtained by the contractor.

Recommendations:

The breaches in physical security and the employment of persons with possible criminal records as security guards places the safety of YSA employees, detained youth, and visitors at risk. These security breaches further allow contraband such as illegal drugs and weapons to enter the facility undetected. Accordingly, we recommend that the YSA administrator immediately take the following measures:

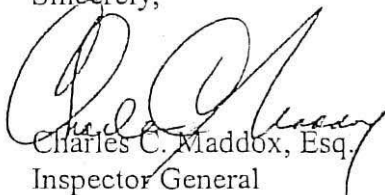
1. Coordinate with OCP and OPM to provide adequate policies, procedures, and training for security guards to ensure that proper searches of all bags and packages of visitors and employees entering the secure detention facility are conducted.
2. Coordinate with OCP and OPM to provide adequate policies, procedures, and training for security guards to ensure that effective frisk and pat search procedures for visitors and employees entering the secure detention facility are conducted.
3. Ensure that the gatehouse metal detector is operating and in use at all times.

4. Work with OCP and OPM to ensure that at least two security guards are present at the perimeter entrance gate and that all entrance security policies and procedures are adhered to.
5. Take immediate action to have the front gate restroom facilities repaired so that guards will not have reason to leave the post unsecured.
6. Work with OCP and OPM to ensure that security guards have received a criminal records clearance prior to assignment at YSA.
7. Work with OCP and OPM to ensure proper monitoring and performance evaluation of security guards assigned to YSA security posts.

Please provide your comments to this MAR by October 23, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report only to those personnel who will be directly involved in preparing your response.

Should you have any questions or desire a conference prior to preparing your response, please contact Alvin Wright, Jr., Assistant IG for Inspections and Evaluations, at 202-727-9249.

Sincerely,



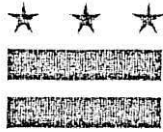
Charles C. Maddox, Esq.
Inspector General

CCM/AW/lp

cc: Mr. Robert C. Bobb, City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Youth Services Administration
Oak Hill Youth Center



MEMORANDUM

TO: All Oak Hill Staff

FROM: Nathaniel D. Williams Jr. *N.D.W.*
Assistant Superintendent, Operations

DATE: 8.7.02

SUBJECT: Contraband Items

For the safety of all staff at Oak Hill Youth Center the below listed items will be considered as "CONTRABAND". Any staff or individuals entering the institution will not be permitted to bring these items into Oak Hill Youth Center.

CONTRABAND ITEMS

1. Non-Prescription Drugs
2. Tear Gas (Pens, Canisters, Guns)
3. Knives (of any kind)
4. Black Jacks, Slap Sticks
5. Brass Knuckles
6. Firearms (of any kind)
7. Explosive Materials or Devices
8. Razor Blades
9. Disposable Razors
10. Alcoholic Beverages
11. Personal Handcuffs, Leg Irons, Keys
12. No glass objects
13. Metal Eating Utensils (forks, spoons, knives)
14. Can Openers (metal type)
15. Sexually Suggestive Materials (magazines, drawings, sketches, etc)
16. Videos (VHS, DVD, BETA, etc.)*
17. Cameras of any kind *
18. Cellular Phones *
19. Aerosol Cans (hair spray, paint deodorant)
20. Hazardous substances (gasoline, lye, poisons, cleaning fluids, acids)*
21. Tobacco products (cigarettes, chewing tobacco, etc)
22. Cigarette lighters and matches
23. Currency (residents only)

24. Pagers (residents and visitors only)
25. Radios (all types; residents only)*
26. Jewelry (rings, watches, chains, bracelets, necklaces, etc; residents only)
27. Sunglasses (residents only)**
28. Baseball Caps (residents only)*
29. Koofi Caps (resident only) *
30. Open Beverage Containers
31. Magic Markers, Paints, Art Supplies, Pens, Pencils (residents only)***
32. Nail Polish (residents only)
33. Personal Clothing (residents only)*

* - Unless written authorization given by the Superintendent

** - Unless for medical reasons (must be verified by Medical)

*** - These items may be used by residents while under adult supervision but must be collected by the adult upon completion of use.

Possession of any of the aforementioned listed items by any resident constitutes a violation of Youth Services Administration policies.

Any staff member (YSA, DCPS, Mental Health, Medical, etc) observing any resident in possession of **CONTRABAND** is to confiscate it immediately and arrange for its secured storage. In addition, an Incident Report will be prepared and submitted to the Supervisory Correctional Officer of the Day (OD) so that appropriate disciplinary action can be taken.

CONTRABAND is any item, article or thing that is not issued from the facility, or not specifically authorized for use by resident or staff by the Superintendent.

This **CONTRABAND LIST** will be posted in all housing units and discussed with staff and residents quarterly.

YOUTH SERVICES ADMINISTRATION
CENTRAL ADMINISTRATION BUILDING
OFFICE OF SECURITY AND INVESTIGATIONS
8300 RIVERTON COURT
LAUREL, MARYLAND 20707

February 18, 1997

SUBJECT: POST ORDER > VISITATION

REFERENCE: Oak Hill Youth Center Gatehouse

The purpose of this order is to clearly define the established procedures to be followed by all Youth Services Administration personnel who are charged with the responsibility of conducting searches of individuals entering the facility for weekend visitation with residents.

All visitors will be subjected to a Frisk or Pat search of their clothing prior to entry into the facility.

Frisk or Pat Search: A frisk or pat search involves a physical search by staff of a fully clothed person. In addition a hand held body frisker or the stationery metal detector can also be utilized to conduct search of an individual's clothing prior to the staff running his or her hands over the clothing of the visitor to detect contraband items.

The general guidelines for conducting a frisk or pat search are:

Inform the visitor that he or she is to be searched

Have the visitor empty everything out of his or her pockets and remove any coats, hats, or other outer clothing items.

To begin the actual search, have the visitor face the staff and spread the arms horizontally to the side and spread the legs about a foot apart.

With the visitor's arms and feet spread, start at the visitor's head and neck and move your hands across the shoulders and down the arms, thoroughly passing over every part of the arms, including into the armpits.

Moving back to the torso, pass the hands over the back, the entire chest (male only) and the abdominal area. Waist, waistband and belt as well as collars, cuffs, seams and lining of all clothes are to be carefully searched.

Next, move down the outside and inside of each leg, including the crotch area

Inspect shoes, inner linings, soles, heels and have visitor remove socks and check, make a visual inspection of the feet (poise each foot and wiggle the toes).

Appendix 5

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Youth Services Administration



November 26, 2003

Mr. Charles C. Maddox
Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

Dear Mr. Maddox:

I am in receipt of your Management Alert Report (MAR 03-1-007) dated October 9, 2003, in which you delineated some of the security breaches that your investigators observed during their investigation of the Youth Services Administration.

Since the issuance of this Management Alert Report, many security changes and enhancements have been made at the Oak Hill Youth Center. First of all, I am pleased to inform you that YSA has cancelled the security contract with the Office of Property Management's Protective Services Division effective November 15, 2003. In lieu of this contract, YSA has entered into a Memorandum of Understanding with the District of Columbia Department of Corrections.

The MOU with the Department of Corrections states that DOC will:

- Provide security at the Oak Hill Youth Center;
- Provide DOC Employees to man all security posts inside and outside of the facility;
- Institute security measures that prevent the introduction of contraband into the facility by searching bags, packages, containers and other personal items of employees and visitors entering the security detention facility;
- Ensure that all electronic equipment is being utilized in conjunction with ACA Standards at Juvenile Correction Facility, (metal detectors);
- Thoroughly frisk, pat search, and require all staff, and visitors entering the facility to empty their pockets when entering the facility;
- Provide at a minimum two correctional officers at the security check point at the Oak Hill Facility to ensure that appropriate security coverage is present at the check point and sally-port;
- Provide the appropriate number of security staff on each shift in order to provide relief for any security officer who might need to leave his/her post;

As it pertains to your concerns regarding the lack of criminal background checks, YSA does forward to the Metropolitan Police Department the names of newly hired individuals so that a security report can be run. The Youth Services Administration has requested on several occasions that we be granted access to the National Crime Information Center/Wales System (NCIC), in order to perform background checks on all of our employees. However, due to our status as a Human Services Department, we have not been given permission to obtain the equipment and/or access to NCIC processing. In order to ensure that we are cognizant of information about prospective employees, I have requested that funding be placed in the FY 2005 Budget so that we can contract with the Metropolitan Police Department to perform NCIC background checks on all YSA employees.

As you are aware, the Youth Services Administration is experiencing a restructuring and reorganization internally and externally; to that end, enhancements are being made consistent with ACA Standards and industry best practices. We are in the process of taking back all control regarding this agency and ensuring that our youth are provided with the appropriate level of services as well as ensuring that all matters associated with our youth meet industry standards.

Should you have any questions regarding these changes, I am available to discuss them with you.

Sincerely,



John Manuel
Deputy Administrator for Secure Programs (Acting)

cc: Carolyn Graham, Deputy Mayor, Children, Youth Families and Elders
Robert Bobb, City Administrator
Yvonne Gilchrist, Acting Director, DHS
Vanessa Chappell-Lee, Deputy Director, DHS
Rick Love, Corporation Counsel
Martha Mullens, Corporation Counsel
Peggy Massey, Chief of Staff, DHS

Appendix 6



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

**MOTOR POOL & MOTOR VEHICLE OPERATOR
LICENSING DEFICIENCIES AT OAK HILL YOUTH CENTER**

MAR 03 – I - 006
SEPTEMBER 11, 2003

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Charles C. Maddox, Esq.
Inspector General



September 11, 2003

Leticia Lacomba
Acting Administrator
Department of Human Services
Youth Services Administration
8300 Riverton Court
Laurel, MD 20724

Dear Ms. Lacomba:

This is a Management Alert Report (MAR 03-I-006) to inform you of significant issues that have come to our attention as a result of our inspection of the Department of Human Services, Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia (District) government official.

Background:

The YSA maintains a fleet of buses and passenger vehicles to transport residents, trucks for transporting supplies, and other vehicles used for general maintenance at YSA facilities. The inspection team (team) noted several deficiencies within the YSA Facilities Maintenance Division motor pool located at the Oak Hill Secure Detention Facility.

Observations:

1. More than one-half of all YSA vehicles in the Oak Hill motor pool have expired inspection stickers, and employees operate these vehicles in violation of District law. In addition, many vehicles have not had semi-annual preventive maintenance checks required by Department of Public Works regulations.

During an inspection of the YSA motor pool, the team observed 10 vehicles with either no inspection stickers or expired stickers. As a result, the team obtained a list of all vehicles assigned to YSA; this list shows that 32 of 62 vehicles have expired inspection stickers.

Title 18 DCMR § 602.4 states:

It shall be unlawful for any person to operate, park, or permit to be operated or parked on public space any vehicle bearing current District of Columbia tags, except a vehicle exempt under the provisions of § 602.3,¹ unless there is displayed on the right side of the vehicle's windshield one of the following:

¹ None of the exemptions listed in Section 602.3 apply to this issue.

- (a) A current District of Columbia inspection sticker;
- (b) A temporary sticker issued by the Director; and
- (c) A temporary registration certificate issued by a registered District of Columbia dealer or repair shop when transferring ownership for registration purposes.

The team found additionally that expired inspection stickers had been removed from vehicles in order to prevent employees from driving these vehicles. However, management indicated that some employees continue to operate the vehicles that lacked valid inspection stickers outside of the Oak Hill compound in violation of District regulations.

The team also noted that 26 of 62 vehicles had not received semi-annual Preventive Maintenance (PM) checks as required by Department of Public Works (DPW), Fleet Management Administration (FMA) procedures. The FMA Manual states that "all vehicles will be scheduled at least semiannually [PM inspection]." Fleet Management Administration, D.C. Department of Public Works, Procedure 7-1-7, Fleet Services Division Manual 97 (1999). In addition, FMA policies state that "the [r]epeated failure to comply with PM inspection schedules may result in a restriction of vehicle use and/or the refusal of fuel."² *Id.* at 89.

YSA managers stated that only one DPW mechanic is available to service the entire fleet of YSA vehicles at Oak Hill during 2 days of the week. Consequently, the mechanic cannot adequately service YSA vehicles in a timely manner, thereby delaying necessary vehicle repairs and maintenance.

2. YSA employees operate government vehicles without valid state drivers licenses and government motor vehicle identification cards.

Title 18 DCMR 18 § 100.2 states that "[n]o person, except those expressly exempted by § 100.3,³ shall drive any motor vehicle in the District of Columbia unless he or she has a valid license under the provisions of this chapter." Similarly, YSA Policy Number 9.11, Section V(A)(3), dated April 15, 2000, states that "[a]ll employees must possess a valid state driver's license from D.C., Maryland or Virginia, to operate a District owned or leased vehicle." Section V(A)(4) further provides that "[a]ll employees must possess and maintain on their person, a valid D.C. Government Motor Vehicle Driver Identification Card."

The team obtained documentation from YSA management showing that 32 YSA employees authorized to drive District vehicles have not provided proof of their state driver's license and D.C. Government Motor Vehicle Driver Identification Cards. The team also obtained documentation showing that 38 employees have expired D.C. Government Motor Vehicle Driver Identification Cards.

² Pursuant to Mayor's Order 2000-75, the Department of Public Works, Fleet Management Administration is responsible for maintaining the fleet management program of the District government. This includes vehicle maintenance, repair, and replacement for all District agencies. However, the agency heads of the Metropolitan Police Department, Department of Corrections, and Fire and Emergency Medical Services may, at their discretion, continue to procure, acquire, maintain, repair, and dispose of non-emergency vehicles and motor equipment used by their agencies.

³ These exemptions do not apply to the issue identified in this MAR.

These violations of District regulations and YSA policies could place the safety of the public, YSA employees, and youth transported at risk and create liability for the city when YSA vehicles that are not properly inspected and repaired, are driven by individuals who are not qualified to drive.

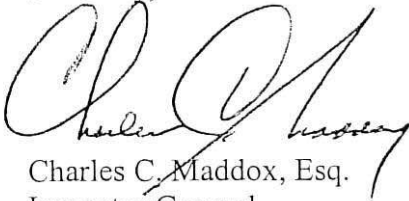
Recommendations:

1. That the YSA Administrator ensure that all vehicles are properly inspected in accordance with District Municipal Regulations.
2. That the YSA Administrator ensure that employees do not operate vehicles without valid inspection stickers.
3. That the YSA Administrator ensure that all vehicle operators maintain current state driver's licenses and D.C. Government Motor Vehicle Identification Cards.
4. That the YSA Administrator ensure that semi-annual preventive maintenance checks are conducted on all YSA vehicles.
5. That YSA coordinate with DPW to increase staffing levels for mechanics assigned to Oak Hill or allot additional days per week for the DPW mechanic to service and maintain YSA's fleet of vehicles.

Please provide your comments to this MAR by September 25, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report only to those personnel who will be directly involved in preparing your response.

Should you have any questions or desire a conference prior to preparing your response, please contact Alvin Wright, Jr., Assistant IG for Inspections and Evaluations, 202-727-9249.

Sincerely,



Charles C. Maddox, Esq.
Inspector General

CCM/AW/LP/jcs

cc: Mr. John A Koskinen, City Administrator, Office of the City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

Appendix 7

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES



Youth Services Administration

September 25, 2003

Charles C. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th Street, NW
Washington, DC 20005



2003 SEP 27 AM 9:52

Dear Mr. Maddox:

The following is in response to the Management Alert Report (MAR 03-I-006) dated September 11, 2003 which informed me, as Acting Administrator, of significant issues that came to your attention as a result of an inspection of the Department of Human Services, Youth Services Administration (YSA). After reviewing the report, I concur with the observations and recommendations. Therefore, the following corrective action plan will be put in place immediately in order to correct these deficiencies:

1. The YSA Acting Administrator will replace all the YSA vehicles as it has been assessed by the mechanic that none of these vehicles will pass inspection.

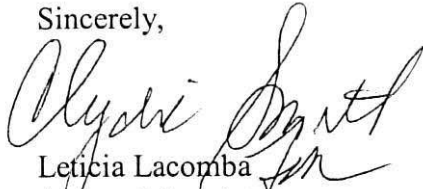
Time Frame – 60 days

2. The YSA Acting Administrator will ensure that once all vehicles have been replaced, the YSA motor pool supervisor will monitor compliance with the semi-annual preventive maintenance checks as well as with the inspection required by District Municipal Regulations.
3. YSA and the Department of Public Works (DPW) have agreed to one full time mechanic to be assigned to YSA.
4. The YSA Acting Administrator has instructed management that prior to the issuance of a government vehicle to any YSA employee, the Motor Vehicle Supervisor will ensure that the employee have a valid state drivers license and a government motor vehicle identification card.

MAR Response to Charles Maddox
September 25, 2003
Page 2

If you have any questions or require additional information, please contact me at (240) 456-5000.

Sincerely,



Leticia Lacomba
Acting Administrator

Cc: Herbert Tillery, Interim City Administrator, Office of the City Administrator
Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders
Yvonne Gilchrist, Acting Director, Department of Human Services
Vanessa Chappell-Lee, Acting Deputy Director for Program, Department of
Human Services

Appendix 8



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

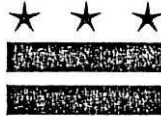
**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

**INSUFFICIENT COMMUNICATION EQUIPMENT
AT OAK HILL YOUTH CENTER**

MAR 03 – I - 008
NOVEMBER 20, 2003

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



November 20, 2003

Yvonne D. Gilchrist
Acting Director
Department of Human Services
2700 Martin Luther King Jr. Ave., SE
801 East Building
Washington, DC 20032

Vanessa Chappell-Lee
Deputy Director for Programs
Department of Human Services
8300 Riverton Court
Laurel, MD 20724

Dear Ms. Gilchrist and Ms. Chappell-Lee:

This is a Management Alert Report (03-I-008) to inform you of significant issues that have come to our attention as a result of our inspection of the Department of Human Services Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia government official.

Background:

The inspection team (team) observed a lack of sufficient and reliable communication equipment in a number of locations at the Oak Hill Youth Center detention facility (Oak Hill) in Laurel, Maryland. This deficiency threatens overall safety and security, and particularly impairs the ability of Youth Corrections Officers (YCOs), transportation officers, treatment team leaders, and social services representatives to perform their jobs effectively.

Observations:

1. Some YCOs do not have the two-way radios that are used to communicate with Oak Hill's Security Control Office in an emergency. This deficiency jeopardizes an officer's safety and compromises overall security at the facility.

YCOs provide security and supervision within the various education, recreation, treatment, and residential buildings, and escort youth between buildings on the secured grounds. On multiple visits to Oak Hill, the team noted that many of the YCOs on duty in the housing units were not carrying two-way radios. YCOs stated that often there is only one radio available within each housing unit¹, even though there may be two or more officers working during a shift. The team also observed YCOs without two-way radios escorting and supervising youth in areas other than the housing units. Several radios were in poor condition. For example, one appeared to be held together with clear tape, while another was bound with rubber bands.

The quantity and condition of the two-way radios represent a significant threat to the safety of YCOs, especially those working in the housing units. If there is only one two-way radio in a unit, and the officer carrying that radio is involved in an altercation that renders the radio inoperable or inaccessible, other officers on duty in the unit may be unable to request assistance from the Security Control Office in a timely manner. In that scenario, an officer would have to seek out the nearest, available wired telephone.

2. Some of the wired telephones located in the YCO offices of the housing units are not functioning.

It is critical that the YCO office in each housing unit has a functioning telephone as backup to the two-way radios so that if a radio malfunctions, YCOs can communicate with the Security Control Office. If YCOs do not have access to an operable two-way radio in an emergency, their safety and that of a facility's youths may depend upon a working telephone. The team visited Oak Hill's housing units on September 10, 2003, and noted the poor condition and inadequate number of functioning wired telephones. YCOs on duty in one unit stated that their telephone had not worked since late June 2003, and they did not have access to another one. The team also reviewed documents in the Facilities Management Division and noted several unresolved telephone repair requests that were over 2 weeks old.

3. An inadequate number of telephones for youths' personal calls contributes to security risks in the housing units, and in one observed instance, violated the Jerry M. Consent Decree.

As stipulated in the Jerry M. Consent Decree (Decree)², "children are entitled to two telephone calls per week of ten minutes each" and "telephones will be located on each living unit." *Jerry M. v. District of Columbia*, Civ. No. 1569-85 (D.C. Super. Ct. July 24, 1986). Our inspection revealed that the number of telephones available for these calls in the living units is insufficient

¹ Oak Hill housing units 7, 8, 9, and 10 each have an "A" unit and a "B" unit, which the inspection team views as two separate housing units.

² In 1985, in an effort to improve conditions at Oak Hill and two other juvenile facilities operated by the District, attorneys filed a class-action lawsuit against the District on behalf of detained and committed youth. In 1986, the District settled the lawsuit by negotiating and agreeing to the provisions of the Jerry M. Consent Decree, a court order that enumerates minimum standards for various conditions and programs at Oak Hill.

and in at least one unit violates the Decree. As mentioned above, YCOs in one unit stated that their telephone had not worked since June 2003 and they did not have access to another telephone. This condition prevented the YCOs from providing youths with their biweekly calls from a telephone in the youth's living unit, as stipulated in the Decree.

YSA policy number 18.2, section IV B (1), effective June 29, 2001, states that "[a] case manager, or in their absence a YCO[,] must place all calls for the youth...." According to several YCOs, often, the only phones available for these calls are in the YCO offices. However, case managers and YCOs should not use telephones in the YCO office in order to avoid the risk of a youth creating a disturbance and disabling the YCO telephone. This could create a security emergency, particularly if no two-way radios are available.

4. Transportation officers who escort youths to D.C. Superior Court are not issued radios or cell phones for emergency communication.

Transportation officers escort youths from Oak Hill to D.C. Superior Court on "court buses," and transport youths to treatment facilities within the D.C. metropolitan area in passenger vans. The team interviewed these officers and observed their work practices.

Although drivers of the "court buses" are issued D.C. government cellular telephones, none of the three to four officers escorting youths on the buses and vans are issued either two-way radios or cellular telephones. Consequently, drivers become the primary means of emergency communication with the Oak Hill Security Control Office or other entities that provide assistance. However, security and emergency communication should be the responsibility of the escorting officers. Those officers who elect to use their personal cellular telephones during these trips say they are not reimbursed for official calls, and this expense becomes particularly burdensome during interstate transfers of youths.

5. Some Social Services Division employees do not have working telephones and voice mailboxes.

Social Services Division (SSD) employees, such as treatment team leaders and social services representatives, coordinate the diagnostic assessment and treatment processes for Oak Hill youths. They monitor the completion of initial diagnostic screenings (e.g., substance abuse, education, mental health, and medical condition), conduct individual and group counseling sessions, issue additional diagnostic and treatment referrals, and update each youth's treatment goals and objectives as needed. SSD employees communicate regularly with the youths' families, off-site case managers, and treatment providers. Each treatment team leader and social services representative has office space in an assigned housing unit.

Inspection team members observed that some SSD employees do not have telephones in their unit offices or functioning mailboxes on the facility's voice mail system. Those without telephones must use telephones in another unit or use their personal cell phones. Those without voice mail capability either use their personal cell phones or instruct callers to dial the SSD main phone number and leave a message with the person who answers the phone.

The treatment team leaders and social services representatives provide a vital link among Oak Hill youth, their families, and various agencies and service providers located both within the facility and in the community. These employees provide critical, time-sensitive information and updates to family members and off-site caseworkers. The lack of a telephone or a working voice mailbox seriously impedes an SSD employee's ability to provide responsive care and efficiently interact with all parties participating in a youth's treatment and rehabilitation.

Recommendations:

The lack of sufficient communication equipment for YCOs and transportation officers poses a threat to the overall safety and security of youth and YSA staff both on the grounds of Oak Hill and during the transportation of youth to and from the facility. In addition, the lack of operable telephones and voice mailboxes impedes the delivery of time-sensitive referrals and other vital information, and limits communication between the family members of detained and committed youths and the youths' case managers. Accordingly, we recommend that the YSA Administrator immediately take the following measures:

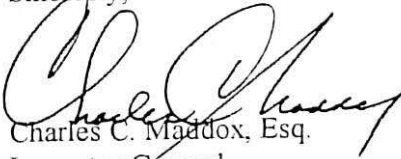
1. Ensure that each Youth Corrections Officer on-duty at Oak Hill has a functional two-way radio for the duration of his or her shift.
2. Repair wired telephones and lines so that both the YCO office and the social services office in each housing unit have working telephones.
3. Provide additional working telephones in each housing unit (i.e. a phone other than the one in the YCO office) to accommodate the youths' right to biweekly telephone calls in accordance with the Jerry M. Consent Decree.
4. Direct a review of communication equipment available for use by transportation officers while on court buses and in passenger vans to ensure that at least one member of each transportation unit, in addition to the driver, is able to communicate with the Oak Hill Security Control Office as well as with outside public safety agencies. If there is insufficient equipment available, the Administrator should acquire additional communication equipment.
5. Ensure that employees in the Social Services Division (treatment team leaders, social services representatives, and their supervisors) have functioning telephones and voice mailboxes.

Please provide your comments on this MAR by December 5, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response.

MAR to Yvonne D. Gilchrist and Vanessa Chappell-Lee
November 20, 2003
Page 5

Should you have questions or desire a conference prior to preparing your response, please contact Lawrence Perry, Director of Planning and Inspections, at 202-727-8490.

Sincerely,



Charles C. Maddox, Esq.
Inspector General

CCM/ef

cc: Mr. Robert C. Bobb, City Administrator, Office of the City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

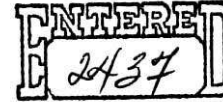
Appendix 9

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES



Office of the Director

December 5, 2003



Mr. Charles Maddox
Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

Dear Mr. Maddox:

I am in receipt of your Management Alert Report (03-I-008) in which you raised concerns regarding the lack of sufficient and reliable communication equipment in many of the housing units at the Oak Hill Youth Center (OHYC).

I was aware of some of the communication problems at OHYC and those problems stem from the wear and tear to an outdated communication system that needs a complete overhaul. The telephones at the OHYC have been placed on a fast track for repair, however, until the Office of the Chief Technology Officer (OCTO) and Verizon Communications can effectuate these changes, I have instituted new procedures, which provide appropriate communication to the staff and youth at OHYC.

First of all I have ordered that:

- Twenty-five additional two way radios be placed in each of the housing units so that Youth Correctional Officers (YCOs) can communicate with OHYC Control Center. These radios have been assigned to each housing unit and YCOs on duty have access to the radios.
- YSA, in conjunction with the Deputy Director's Office and the Office of the Chief Technology Officer and Verizon Communications, has completed a thorough assessment regarding the telecommunication needs of YSA and they are in the process of establishing a corrective action plan.
- Because of the difficulty with the wiring system at Oak Hill Youth Center, many of the telephones are inoperable. Therefore, in an attempt to alleviate the problem, I have placed cellular phones in each housing unit for the YCOs to use. Youth in the units will have access to the phone that had been used by the Supervisors in the units. This system will ensure that we are in compliance with

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Letter to Charles Maddox
Re: Management Alert Report
Page 2

the Jerry M. Consent Decree requirement, that a special phone be designated for youth usage.

- I have issued cellular phones to transport officers who escort youth to D.C. Superior Court.
- As it pertains to access to telephones in the social services unit, supervisors have cell phones with speaker capability and in the event it is necessary to have telephone conferences, these phones will be utilized. In addition, the telephones in the secretarial sections of the social services unit are operational and social workers may receive voice mail messages there. While this response is not one that is best for the employees, the social services unit is an area that will have major renovation as it pertains to communication services once OCTO and Verizon Communications complete the enhancement designs for the OHYC communication system. I will continue to ensure that staff has access to phones even if I must reassign cell phones to each member of the social services staff.

While I am cognizant of the fact that cellular phones are not the most effective manner to operate a facility, we are confronted with major communication system problems which will required extensive time and work to remedy. As YSA goes through a restructuring and reorganization, physical plant enhancements will be made that complement the needs of the staff and youth.

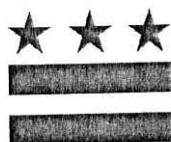
Should you have any questions regarding these procedural and equipment changes, I am available to discuss this matter with you. I can be contacted at (202) 279-6002.

Sincerely,


Yvonne Gilchrist
Director

cc: Robert Bob, City Administrator
Carolyn N. Graham, Deputy Mayor for Children, Youth, Families and Elders
Vanessa Chappell-Lee, Deputy Director for Programs, DHS
James Parks, Deputy Director for Administration, DHS
Marceline Alexander, Interim Administrator, YSA

Appendix 10



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

DEFICIENCIES IN UNIT 6 (FEMALE DETAINEES)

MAR 03 – I - 009
JANUARY 7, 2004

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



January 7, 2004

Yvonne D. Gilchrist
Director
Department of Human Services
2700 Martin Luther King Jr. Ave., SE
801 East Building
Washington, DC 20032

Marceline D. Alexander
Acting Administrator
Youth Services Administration
8300 Riverton Court
Laurel, MD 20724

Dear Ms. Gilchrist and Ms. Alexander:

This is a Management Alert Report (MAR-03-I-009) to inform you of significant issues that have come to our attention as a result of our inspection of the Department of Human Services, Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of District of Columbia government officials.

Background

YSA houses committed and detained female residents in a separate housing unit (Unit 6) at the Oak Hill Youth Center (OHYC) in Laurel, Maryland. Unit 6 is in an isolated area approximately one mile from the OHYC Security Control Center. During a recent visit to Unit 6, the inspection team (team) observed serious deficiencies that impair the ability of Youth Correctional Officers (YCOs) to effectively maintain the safety and security of residents and to ensure their own safety as well.

Observations

1. Unit 6 had only one two-way radio for use by five security officers.

Unit 6 has five YCOs on duty who provide security and supervision of female residents housed at OHYC. They escort the residents from the unit to medical appointments, court appearances, and the main secure detention facility. However, the YCOs on duty in this unit must provide 24-hour security with only one two-way radio. YCOs stated that often the radio malfunctions, leaving them unable to communicate with the security control center.

The lack of a sufficient number of two-way radios and the poor condition of the one radio on hand represent a significant threat to the general safety and security of the YCOs and residents. For example, if there were an altercation or other disturbance at Unit 6, residents and YCOs alike would be at risk of sustaining serious injuries that might be avoided if the YCOs have an adequate number of properly functioning radios with which to summon immediate assistance.

2. There is no telephone in the YCO security office.

It is critical that each YCO office in each housing unit has functioning telephones as backup to the two-way radios in case the radios malfunction and there is an immediate need for assistance.

The YCO security office is not equipped with a telephone. Therefore, YCOs have to rely solely on two-way radios as their only means of communication. In addition, a backup telephone system is particularly necessary in the YCO office at Unit 6 because of the current two-way radio problems in that unit as discussed above.

3. The doors to residents' rooms must be manually unlocked in the event of fire or other emergency, but only two YCOs have keys.

Normally, there are 8-20 female residents detained in individual rooms within the Unit 6 facility. Residents are periodically locked in their rooms during the day for a variety of reasons, such as disciplinary problems or a facility lockdown. Residents are also locked in their rooms at night during sleeping hours.

Only two of the five YCOs have keys to the individual rooms, and each door must be locked and unlocked manually. This situation creates the potential for a catastrophe if, during an emergency, the key-holders are incapacitated, and other YCOs are unable to quickly unlock the doors so residents can be moved to safety.

According to the Fire and Emergency Medical Services employee who conducts fire inspections at OHYC, the manual locks on the doors of detainees' rooms do not violate current codes or regulations. However, the inspection team remains concerned about the safety risks associated with sole reliance on a manual system that might be compromised during the chaos of a fire or other emergency.

4. **The electronic security monitoring system in Unit 6 is inoperative, and the facility's exterior lighting is inadequate.**

YSA Post Orders dated May 1992 states, "Correctional staff are to make sure that all electronic security systems are on-line, operational, and report all malfunctions to a Supervisor. The malfunction and actions taken shall be recorded in the logbook."

Although Unit 6 has security monitoring equipment in the YCO office to provide real time viewing of the hallways, recreational areas, and day-to-day operations throughout the unit, the equipment is inoperative. The team found that several cameras used for electronic monitoring were outdated and performing inadequately. YCOs stated that the electronic security system has been inoperative for several years. The lack of adequate monitoring equipment prevents proper surveillance of the secured areas, and could allow residents to escape from the facility undetected.

In addition, YCOs stated that the illumination provided by the exterior security lights in the parking area of the facility is inadequate. They fear that intruders could lie in wait in dark or inadequately lit areas around the building, and then assault them as they walk to their cars at the end of each shift.

5. **The metal detector and hand wand at the entrance of the Unit are not always activated.**

The American Correctional Association (ACA) standards for Juvenile Correction Facilities recommend the use of metal detectors at entrance gates. Unit 6 uses a walk-through metal detector similar to those found at airports, but it had not been activated when the inspection team visited. Unit 6 also has a hand wand to scan employees and visitors for metal objects, but the hand wand did not have batteries and was not being used. Consequently, visitors could bring contraband metallic objects, such as guns and knives, into the unit without detection.

6. **The YCO security office's lack of air conditioning and heating creates uncomfortable working conditions.**

ACA standards recommend that temperatures in living and work areas be appropriate to the summer and winter comfort zones, and that employees be able to mechanically raise or lower temperature and humidity to an acceptable comfort level. However, the team observed that there were no operating heating or air conditioning units in the YCO security office, which serves as the unit's command post. Consequently, YCOs often must tolerate either extreme heat or extreme cold on each shift.

7. **YCOs are not issued proper uniforms.**

YCOs are issued uniforms, which they must wear while on duty. These uniforms should be suitable for both winter and summer months. During the inspection, Unit 6 YCOs stated that they have not received winter uniforms and are forced to wear summer uniforms that are

inappropriate for the winter season. They further stated that their uniforms often are two and three sizes too large and must be altered at their own expense. Despite requests for seasonal and appropriately sized uniforms, YCOs stated that their requests have not been accommodated.

Recommendations

The deficiencies cited above in the areas of communication, electronic monitoring, security lighting, metal detectors, and the work environment impede YCOs' ability to work effectively and efficiently, and create potential hazards for both YCOs and residents. Accordingly, we recommend that the YSA Administrator take the following actions immediately:

1. Ensure that each Youth Correction Officer on duty in Unit 6 has a functional two-way radio for the duration of his or her shift.
2. Ensure that a working telephone is installed in the YCO security office.
3. Ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.
4. Explore the feasibility of a central locking and unlocking system for all doors in the residential area so there can be fast egress in the event of a fire or other emergency.
5. Ensure that an emergency buzzer, direct phone line, or other notification device is connected between Unit 6 and the OHYC security control center to provide an alternative means of immediate communication in the event of an emergency.
6. Ensure that all electronic security monitoring equipment is repaired or replaced.
7. Ensure that YCOs keep the metal detector activated at all times, that batteries are installed in the hand scanner, and that the scanner is used in accordance with procedures.
8. Ensure the installation of adequate lighting for the exterior building perimeter.
9. Ensure that sufficient air conditioning and heating is provided in the YCO security office.
10. Ensure that YCOs are issued properly sized and seasonal uniforms.

Please provide your comments on this MAR by January 20, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response. Should you have questions or desire a conference prior to preparing your response, please contact Lawrence Perry, Director of Planning and Inspections, at 202-727-8490.

Sincerely,

A handwritten signature in cursive script, reading "Austin A. Andersen". The signature is fluid and extends to the right with a long, sweeping tail.

Austin A. Andersen
Interim Inspector General

AAA/lp

cc: Mr. Robert C. Bobb, City Administrator
Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders
James Parks, Deputy Director for Administration, DHS
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

Appendix 11

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Human Services
Youth Services Administration



Marceline D. Alexander
Interim Administrator

February 13, 2004

Mr. Austin A. Anderson
Interim Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

RE: *Management Alert Report 03-I-009 (Deficiencies in Unit 6 at Oak Hill Youth Center)*

Dear Mr. Anderson:

This correspondence is transmitted to you in response to Management Alert Report 03-I-009 dated January 7, 2004, in which the Office of the Inspector General ("OIG") makes seven sets of observations and ten recommendations to the Youth Services Administration ("YSA") in connection with deficiencies identified by your inspection teams at the Oak Hill Youth Center ("OHYC") in Unit 6 (Spruce Cottage).

In response to your specific recommendations, please be advised as follows:

1. *Ensure that each Youth Correction[al] Officer on duty in Unit 6 has a functional two-way radio for the duration of his or her shift.*

In the response to Management Alert Report 03-I-008, the Director of the Department of Human Services, Yvonne D. Gilchrist, advised OIG of certain new procedures to address communication equipment deficiencies at OHYC. YSA has issued four additional two-way radios to the Unit Supervisor in Unit 6. In the event additional radios are necessary, instructions have been given to the Officer of Day to ensure that any staff member who needs access to a two-way radio receives this equipment immediately.

2. *Ensure that a working telephone is installed in the YCO security office.*

Please see the response above to recommendation 1. In addition, please be advised that the telephone that was broken during your team's visit has been repaired and is operational.

3. *Ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.*

YSA provided a response to an identical recommendation contained in Management Alert Report 03-I-010. YSA has advised OIG that, in order to provide additional security measures that will allow faster evacuation of the housing units, including Unit 6, YSA will install a lock box in the security office, and the unit manager, supervisory correctional officer and the officer of the day will have access in the event of a fire or other emergency.

4. *Explore the feasibility of a central locking and unlocking system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency.*

YSA provided a response to a virtually identical recommendation contained in Management Alert Report 03-I-010. OHYC is a facility that is in need of many capital improvements. We have and continue to investigate the feasibility of installing electronic door releases; however, due to the physical layout of OHYC, this plan has never been feasible. In order to provide additional security measures that will allow faster evacuation of the housing units, YSA will install a lock box in the security office, and the unit manager, supervisory youth correctional officer and the officer of the day will have access to the lock box in the event that an emergency occurs.

5. *Ensure that an emergency buzzer, direct phone line, or other notification device is connected between Unit 6 and the OHYC security control center to provide an alternative means of immediate communication in the event of an emergency.*

See responses to recommendations 1 and 2 above.

6. *Ensure that all electronic security monitoring equipment is repaired or replaced.*

YSA has repaired the electronic security monitoring system in Unit 6.

7. *Ensure that YCOs keep the metal detector activated at all times, that batteries are installed in the hand scanner, and that the scanner is used in accordance with procedures.*

The metal detector and hand wand equipment at Unit 6 have been replaced. The equipment is operational and the staff has been instructed to have this security equipment operational at all times.

8. *Ensure the installation of adequate lighting for the exterior building perimeter.*

YSA is aware of the need to upgrade the facility's exterior lighting, and arrangements are being made to upgrade the electrical power so that institutional lighting can be enhanced for Unit 6.

9. *Ensure that sufficient air conditioning and heating is provided in the YCO security office.*

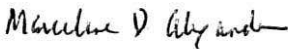
The heating and air conditioning ("HVAC") systems at Unit 6 are operational. However, due to the age of the HVAC system, there are no individual thermostats in the units that allow staff to regulate the temperatures in each unit. YSA currently is investigating ways in which we can provide facility enhancements that will address this situation.

10. *Ensure that YCOs are issued properly sized and seasonal uniforms.*

YSA provides all YCOs with agency-ordered uniforms. However, the uniforms that were purchased in the past were in large sizes. This problem is being corrected and the procurement staff has been instructed to purchase additional uniforms in the appropriate sizes. Once these uniforms are delivered, YCOs will be issued appropriate uniforms.

Should you have any questions regarding these responses, please contact Clydie A. Smith, Correctional Program Officer, Youth Services Administration, at (240) 456-5005.

Sincerely,


Marceline D. Alexander
Interim Administrator

MDA/cas

cc: Robert C. Bobb, City Administrator
Lori E. Parker, Acting Deputy Mayor for Children, Youth, Families and Elders
Yvonne D. Gilchrist, DHS Director
Vanessa Chappell-Lee, DHS Deputy Director
Mark D. Back, YSA Interim Special Counsel
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

Appendix 12



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

CHARLES C. MADDOX, ESQ.

INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION

MANAGEMENT ALERT REPORT

**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

FIRE SAFETY PROBLEMS

MAR 03 – I - 010

DECEMBER 31, 2003

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



December 31, 2003

Yvonne D. Gilchrist
Director
Department of Human Services
2700 Martin Luther King Jr. Ave., SE
801 East Building
Washington, DC 20032

Marceline D. Alexander
Interim Director
Youth Services Administration
8300 Riverton Court
Laurel, MD 20724

Dear Ms. Gilchrist and Ms. Alexander:

This is a Management Alert Report (MAR 03-I-010) to inform you of significant issues that have come to our attention as a result of our inspection of the Department of Human Services, Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of District of Columbia government officials. During the OIG's inspection of YSA, the inspection team (team) observed a number of serious fire safety deficiencies at the Oak Hill Youth Center (OHYC) in Laurel, Maryland that may threaten the safety of residents and employees.

Background

YSA policies and procedures state that fire hoses or extinguishers are to be available throughout OHYC; emergency evacuation plans must be posted publicly; and fire drills are to be conducted on a quarterly basis.¹ In order to meet OHYC's fire

¹ YSA Administrative Issuance No. 4-004, Part III- Facility Operations and Management, Chapter 4- Safety and Environmental Health. This document establishes policies and procedures for the safety programs, inspections, and fire and evacuation plans for institutional and community based residential facilities within YSA, including OHYC.

prevention and fire safety requirements, the YSA Health and Safety Officer must conduct monthly fire safety inspections of OHYC, and all inspection reports are to be kept on file and available for examination at OHYC. In addition, the Health and Safety Officer must be knowledgeable of the District's 1996 Fire Prevention Code and the 1999 District of Columbia Construction Code Supplement.

Observations

1. Fire extinguishers were not accessible; fire drills were not being conducted; and emergency evacuation plans were not posted in critical areas.

The team found that fire extinguishers were not readily accessible to staff members and residents. Youth Correctional Officers (YCOs) assigned to various security posts throughout OHYC did not have keys to access fire extinguisher lock boxes in the event of an emergency. The team also found that the fire extinguishers in the gymnasium were locked in a closet and were not readily accessible. According to the Recreation Specialist, the extinguishers were removed from the wall mounts to prevent residents from tampering with them.

Further, the team found that mandatory quarterly fire drills were not conducted and emergency evacuation plans were not posted in every building at OHYC. The team reviewed OHYC weekly fire inspection reports for the previous 6 months, but did not find any documentation or notes showing that quarterly fire drills had been conducted of the residential housing units. According to the Facilities Maintenance Foreman and other OHYC employees, fire drills are rarely conducted. The team found that the last documented fire drill was conducted on February 27, 2002.

Although YSA policy does not require that an emergency evacuation plan be posted at every location, the team found that many key locations at OHYC, such as classrooms, vocational buildings, and the gymnasium, lacked posted emergency evacuation plans.

2. OHYC does not have a trained Health and Safety Officer to conduct fire safety inspections.

The team found that OHYC does not employ a Health and Safety Officer who is knowledgeable of the District's 1996 Fire Prevention Code and the 1999 District of Columbia Construction Code Supplement.² Rather, an untrained OHYC maintenance employee currently performs weekly fire safety inspections in conjunction with his other assigned duties. Without proper training, however, this employee cannot ensure that such inspections are conducted in accordance with the fire and construction codes referenced above, and can therefore not ensure the safety of residents and employees of OHYC.

² The District of Columbia FEMS, Fire Prevention Bureau uses the Fire Prevention Code and Construction Code Supplement to ensure fire safety compliance.

The team reviewed a District of Columbia Fire and Emergency Medical Services Department (FEMS), Fire Prevention Bureau fire safety inspection report dated October 8, 2003. The report documented 88 fire safety deficiencies requiring immediate abatement. The team conducted a follow-up inspection based on the FEMS report and noted that as of November 19, 2003, 20 of the 88 deficiencies had not been abated.

The lack of a trained Health and Safety Officer knowledgeable about fire safety and construction codes likely resulted in OHYC's inability to detect and correct fire hazards and the numerous deficiencies documented by FEMS during its fire safety inspection.

3. The locks on housing unit doors are manual and could pose a safety hazard in the event of a fire or other emergency.

During an inspection of OHYC housing units for males, the team noted that the doors to residents' rooms have manual locks that require the use of a key.³ In addition, the Modular Housing Units doors have dead bolt locks with the locking mechanism located on the outside of the doors. In both cases, one of the two YCOs assigned to each housing unit must manually unlock the doors in order for residents to enter or exit their rooms. There is no other method for unlocking or securing the doors.

The team found only one set of keys for each of the 20 resident rooms in each housing unit, although there are two YCOs on duty for each unit. In the event of a fire emergency or disturbance, these conditions could pose a safety hazard to both youths and the YCOs if they are unable to unlock all doors in a timely manner.

Recommendations

The inaccessibility of fire extinguishers, lack of quarterly fire drills, lack of posted emergency evacuation plans, and inability to conduct adequate fire inspections may result in serious injury to youths and employees in the event of a fire emergency. Additionally, without a centrally operated door locking system, the failure to provide all YCOs with keys to resident rooms threatens the health and safety of residents and employees. Accordingly, we recommend that the YSA Administrator immediately take the following measures:

1. Ensure that all employees have access to fire extinguishers at all times.
2. Ensure that the fire extinguishers in the gymnasium are removed from the closet and re-installed on the wall mounts.
3. Ensure that all deficiencies cited by the FEMS Fire Prevention Bureau are abated immediately.

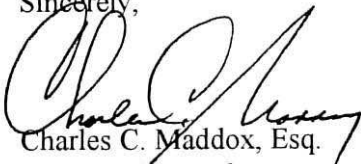
³ The team documented similar concerns about the housing unit for females in OIG MAR-03-009.

4. Ensure that emergency evacuation plans are posted publicly in all key areas of OHYC.
5. Ensure that fire drills are conducted and documented quarterly as required.
6. Hire a trained Health and Safety Officer or provide adequate training to the designated OHYC employee who conducts monthly fire safety inspections.
7. Explore the feasibility of a central locking system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency.
8. Ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.

Please provide your comments to this MAR by January 16, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report only to those personnel who will be directly involved in preparing your response.

Should you have questions or desire a conference prior to preparing your response, please contact Lawrence Perry, Director of Planning and Inspections, at 202-727-8490.

Sincerely,



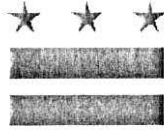
Charles C. Maddox, Esq.
Inspector General

CCM/lp

cc: Mr. Robert C. Bobb, City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders
James Parks, Deputy Director for Administration, DHS
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

Appendix 13

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Human Services
Youth Services Administration



Marceline D. Alexander
Interim Administrator

February 13, 2004

Mr. Austin A. Anderson
Interim Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

RE: *Management Alert Report 03-I-010 (Fire Safety Problems)*

Dear Mr. Anderson:

This correspondence is transmitted to you in response to Management Alert Report 03-I-010 dated December 31, 2003, in which the Office of the Inspector General ("OIG") makes three sets of observations and eight recommendations to the Youth Services Administration ("YSA") in connection with fire safety deficiencies identified by your inspection teams at the Oak Hill Youth Center ("OHYC").

In response to your specific recommendations, please be advised as follows:

1. *Ensure that all employees have access to fire extinguishers at all times.*

YSA follows American Correctional Association ("ACA") standards pertaining to ensuring the safety and well being of its residents and staff at OHYC. To that end, all fire extinguishers are concealed in locked wall areas on each unit. The unit manager and supervisory youth correctional officer on each unit have keys to open the locked wall boxes. In order to provide additional safety measures to each housing unit, YSA will install a lock box in each of the security office's to ensure that the keys are available on the unit should a fire emergency occur.

2. *Ensure that the fire extinguishers in the gymnasium are removed from the closet and re-installed on the wall mounts.*

Please see the response above to recommendation 1. YSA cannot permit fire extinguishers to be readily available where residents can reach them as they pose a security breach and can be used as weapons.

3. *Ensure that all deficiencies cited by FEMS Fire Prevention Bureau are abated immediately.*

Your letter notes that YSA abated 68 of 88 deficiencies identified by the D.C. Fire and Emergency Medical Services Departments ("FEMS") in its fire safety inspection report dated October 8, 2003. FEMS issued the attached misdated reinspection report from December 2003 that itemizes eight unabated deficiencies from the original list. Until last week, four of these items (*i.e.* the fire-rated separation and the door hardware listed in items 4-7) remained unabated. However, the door hardware has been installed and the installation of the fire-rated separation for laundry in the sprinkler room was completed last week with the exception of the door itself which should be completed by February 19, 2004.

4. *Ensure that emergency evacuation plans are posted publicly in all key areas of OHYC.*

YSA will post emergency evacuation plans in every location within the classrooms, vocational buildings, housing units, gymnasium and Administration buildings.

5. *Ensure that fire drills are conducted and documented quarterly as required.*

YSA conducts fire drills in all of the housing units; however, effective immediately, YSA will conduct fire drills in all of the housing units on a quarterly basis and during all three shifts. This procedure will be documented in the weekly fire inspection reports.

6. *Hire a trained Health and Safety Officer or provide adequate training to the designated OHYC employee who conducts monthly fire safety inspections.*

YSA is in the process of recruiting to fill the position of Health and Safety Officer.

7. *Explore the feasibility of a central locking system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency.*

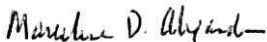
OHYC is a facility that is in need of many capital improvements. We have and continue to investigate the feasibility of installing electronic door releases; however, due to the physical layout of OHYC, this plan has never been feasible. In order to provide additional security measures that will allow faster evacuation of the housing units, YSA will install a lock box in the security office, and the unit manager, supervisory youth correctional officer and the officer of the day will have access to the lock box in the event that an emergency occurs.

8. *Ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.*

See response to recommendation 7 above.

Should you have any questions regarding these responses, please contact Clydie A. Smith, Correctional Program Officer, Youth Services Administration, at (240) 456-5005.

Sincerely,


Marceline D. Alexander
Interim Administrator

MDA/cas

cc: Robert C. Bobb, City Administrator
Lori E. Parker, Acting Deputy Mayor for Children, Youth, Families and Elders
Yvonne D. Gilchrist, DHS Director
Vanessa Chappell-Lee, DHS Deputy Director
Mark D. Back, YSA Interim Special Counsel
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

GOVERNMENT OF THE DISTRICT OF COLUMBIA
FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT
WASHINGTON, D.C. 20001



October 20, 2003

John Manuel
Deputy Administrator
Oakhill Youth Detention Center
8300 Riverton Ct.
Laurel, Maryland
20724

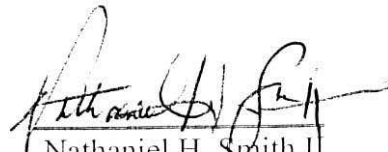
Dear Administrator

On December 18 and 19, 2003 a fire safety re-inspection was conducted at your facility for the Oakhill Youth Detention Center. The inspection was conducted to determine your facility's compliance with the 1996 Fire Prevention Code and the 1999 DC Construction Codes Supplement. The vast majority of violations were abated except for the following items:

- 1) blocked exit in the woodshop f605.1
- 2) 911 placard in modular 2 f322.3
- 3) missing sprinkler wrench in mod 2 F501.1
- 4) no fire rated separation for Laundry in sprinkler room bc711.2
- 5) no door hardware at Cottage 9 F303.4
- 6) no door hardware at Culinary F303.4
- 7) no door hardware at main entrance to Hall A f303.4
- 8) provide written copies of fire evacuation plans for your facility f705.1

Your compliance time is extended until after the 1st of the year, after which time myself and Inspector Farrior will re-inspect. If there are further questions, please call at your convenience.

DWAYNE FARRIOR
Dwayne Farrior
Fire Inspector


Nathaniel H. Smith II
Fire Investigator
Fire Prevention Bureau
(202) 727- 1874

cc: Nathaniel Williams

Appendix 14



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUSTIN A. ANDERSEN
INTERIM INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

**DEPARTMENT OF HUMAN SERVICES
YOUTH SERVICES ADMINISTRATION
OAK HILL YOUTH CENTER**

**ABANDONED BUILDINGS AT OAK HILL YOUTH
CENTER**

MAR 03 – I - 013
JANUARY 28, 2004

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



January 28, 2004

Yvonne D. Gilchrist
Director
Department of Human Services
2700 Martin Luther King Jr. Ave., SE
801 East Building
Washington, DC 20032

Marceline D. Alexander
Acting Administrator
Youth Services Administration
8300 Riverton Court
Laurel, MD 20724

Dear Ms. Gilchrist and Ms. Alexander:

This is a Management Alert Report (MAR-03-I-013) to inform you of significant issues that have come to our attention as a result of our inspection of the Department of Human Services, Youth Services Administration (YSA). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of District of Columbia government officials.

Observations

Oak Hill Youth Center (OHYC), located on a large parcel of land in Laurel, MD, is the former location of Forrest Haven, a District-run facility for severely handicapped youths. The site contains numerous buildings once used for housing, training, and support that have been unused and abandoned since Forrest Haven was closed in 1991. The inspection team (team) found that many of these abandoned buildings have been vandalized and, in some buildings, fires have been set.

Although OHYC facilities maintenance employees stated that the buildings were secure, the team was able to gain access to many of them because the doors were either open or unlocked. The amount of vandalism and debris, such as discarded clothing and other personal items, observed by the team makes it clear that trespassers have easily and consistently accessed the buildings. (See attached photos.)

In addition, the team found that many of these buildings, although not in use, still have active electrical and water service. For example, the building that served as Forrest Haven's laundry still contains commercial-size laundering machines. During a daytime visit to the laundry, the team found that the fluorescent lights in the ceiling were on, possibly since Forrest Haven's closure in 1991.

Accordingly, we recommend that the YSA Administrator take the following actions immediately:

1. Ensure that each abandoned building at the OHYC is secured against vandalism and safety risks;
2. Ensure that electrical and water service to unused buildings is disconnected.

Please provide your comments on this MAR by February 13, 2004. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response. Should you have questions or desire a conference prior to preparing your response, please contact Lawrence Perry, Director of Planning and Inspections, at 202-727-8490.

Sincerely,



Austin A. Andersen
Interim Inspector General

AAA/lp

cc: Mr. Robert C. Bobb, City Administrator
Lori E. Parker, Interim Deputy Mayor for Children, Youth, Families and Elders
James Parks, Deputy Director for Administration, DHS
Councilmember Kathleen Patterson, Chairperson, Committee on the Judiciary

Appendix 15



GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Human Services

Youth Services Administration

04 MAR -3 PM 1:18



Marceline D. Alexander
Interim Administrator

March 2, 2004

Mr. Austin A. Anderson
Interim Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

RE: *Management Alert Report 03-I-013 (Abandoned Buildings at Oak Hill Youth Center)*

Dear Mr. Anderson:

This correspondence is transmitted to you in response to Management Alert Report 03-I-013 dated January 28, 2004, in which the Office of the Inspector General ("OIG") makes two recommendations to the Youth Services Administration ("YSA") regarding abandoned buildings located on the parcel of land in Laurel, Maryland, which includes the site formerly known as Forest Haven, and also includes the Oak Hill Youth Center ("OHYC"). OIG recommends that the YSA Administrator initiate the following actions:

1. Ensure that each abandoned building at the Oak Hill Youth Center is secured against vandalism and safety risks; and
2. Ensure that the electrical and water services to unused buildings are disconnected.

In response to your specific recommendations, please be advised as follows:

While your correspondence generally refers to the OHYC, YSA currently occupies only limited buildings located on the old Forest Haven site. YSA is working with the Office of Property Management ("OPM"), the Office of the Corporation Counsel ("OCC"), and fellow administrations within the Department of Human Services ("DHS") to identify which District of Columbia agency is responsible for securing abandoned buildings on the old Forest Haven site. The preliminary results of our investigation indicate that specific properties discussed in your investigation may belong to DHS's Mental Retardation and Developmental Disability Administration. The DHS Office of the Director will follow up your recommendation.

In addition, YSA has learned that the Forest Haven facility was constructed prior to current water, sewer and electrical standards. YSA cannot disconnect the lights associated with the Forest Haven parcel of land because these electrical systems provide the street lighting necessary to maintain security visibility at the Spruce Cottage (also known as Unit 6 for female residents), along each street in the parcel of the land, for the OHYC Training Academy, and the Union facility. In addition, YSA must maintain water flow because it provides water to all fire hydrants on the property and serves the Woodland Job Corps, which was originally a part of this site.

Should you have any questions regarding these responses, please contact Clydie A. Smith, Correctional Program Officer, Youth Services Administration, at (240) 456-5005.

Sincerely,



Marceline D. Alexander
Interim Administrator

MDA/cas

cc: Robert C. Bobb, City Administrator
Lori E. Parker, Acting Deputy Mayor for Children, Youth, Families and Elders
Yvonne D. Gilchrist, DHS Director
James Parks, DHS Deputy Director
Mark D. Back, YSA Interim Special Counsel